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F 000	INITIAL COMMENTS Annual Certification Survey	F 000		
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. 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 interview and record review, the Facility failed to review and revise the Care Plan to reflect current healthcare needs for 2 of 15 residents (R7 and R10) reviewed for Care Plans in the sample of 15. Findings include: 1. R7's Physician's Order Sheet, dated June	F 280		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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2016, documents he has diagnoses of Parkinson's Disease and Lewy body disease. R7's Incident Reports, dated January 2016 to present, were reviewed and documents R7 has had multiple falls.

On 6/8/16 at 11:30 AM, E1, Administrator, stated, "We have started to use music therapy with (R7) to help prevent falls it seems to work during the day, but not at night. A few weeks ago, we put a box fan in his room to help promote noise reduction and comfort for (R7). The fan worked for a few nights, then he started getting up to turn the fan off. (R7) is 15 minute checks and 1 to 1 intervention when needed."

On 6/8/16 at 3:30 PM, E6, Certified Nurse Aide (CNA), stated, "(R7) is on 15 minute checks and if need be, 1 to 1 intervention. We were using a fan in his room, but then he would get up and turn it off. So we then put the fan out in the hall and that seemed to help, but then someone would turn it off. The music therapy did not work at night (R7) likes it quiet."

On 6/8/16 at 8:16 AM, E7, Unit Aide, stated, "(R7) is on 1 to 1 intervention when he needs to be. I actually sat with him last night. We tried the fan, but that didn't seem to work he kept trying to shut it off."

On 6/8/16 at 12:20 PM, E8, LPN, stated, "(R7) is checked at least every 15 minutes and we do 1 to 1 interventions when needed."

On 6/8/16 at 1:20 PM, E9, CNA, and E10, CNA, both stated that R7 seems to enjoy the music therapy during the day and he is on 1 to 1 intervention when needed.

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On 6/9/16 at 10:15 AM, E4, Licensed Practical Nurse (LPN)/Care Plan Coordinator, stated, "All of (R7's) Temporary Care Plan sheets for falls is used as his working fall Care Plan along with the Care Plan in the computer." E4 also stated, "I fill out a Temporary Care Plan sheet after every fall."

R7's current undated Fall Care Plan does not address the use of a box fan at night, music therapy or 1 to 1 interventions when needed.

The facility's "Post- Fall Huddle" policy, undated, documents, in part, "What should we do to prevent another fall? Inform staff that the intervention chosen should be related to the reason the resident fell. The intervention must be implemented at this time. The intervention will be reviewed by the interdisciplinary team, and may change. These changes will be reflected in the resident's plan of care."

2. R10's Minimum Data Set (MDS), dated 5/13/16, documents R10's has no cognitive impairment.

R10's POS (Physician's Order Sheet) dated 6/9/16, documents in part, diagnoses of presence of artificial wrist joint, unspecified osteoarthritis, contracture unspecified joint, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side. R10's Hospice contract in medical record documents hospice services began 5/4/16.

R10's Care Plan dated 4/23/16, documents in part, "Restorative Programs - Invite/escort me to the AM group session every morning. Encourage

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F 280	Continued From page 3 me to participate every day. Provide me with set up of any equipment I may need to perform all ranges. Instruct me to perform at least 10 reps (repetitions) with each joint. Assist me with verbal/physical cues as needed. Stop ranges if I complain of pain. Assess my range of motion routinely. Provide me with rest periods as needed. Encourage me to participate to my full potential. Notify the nurse if I continue to complain of pain or if I develop decreased ROM (range of motion). Provide a referral to Skilled therapy as needed. Document and participation and performance." On 6/9/16 at 9:22 AM, E22, Restorative Aide, stated, "(R10) is on hospice. We do not do any passive range of motion with her anymore." On 6/9/16 at 12:15 PM, E4 stated, "(R10) is no longer on restorative program but might get gentle bedside range of motion as part of her care. She also no longer wears braces to her knees for contractures." On 6/9/16 at 3:50 PM, E4 stated "All the care plans are up to date and correct." On 6/10/16 at 11:22 AM. E4 stated, "We don't have a restorative flowsheet for (R10) for May (2016). We stopped (R10's) restorative treatment the end of April (2016)."	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	F 309		

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accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to coordinate services with hospice for 1 of 15 residents (R10) reviewed for Hospice services in the sample of 15.

Finding includes:

R10's Physician's Order Sheet, dated 6/9/16, documents in part, "(R10) admit to (hospice) with terminal diagnoses dementia, CVA (cerbrovascular accident), and chronic kidney disease."

R10's Hospice contract in medical record documents hospice services began 5/4/16.

On 6/9/16 at 10:30 AM, the hospice care plan was not found in R10's electronic or paper medical record.

On 6/9/16 at 11:45 AM, E3, Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON),stated, "We just called hospice because we couldn't find (R10's) care plan. Hospice faxed it to us this morning. The regular hospice nurse had surgery. She leaves the information for us but the replacement didn't leave it. I don't know what hospice does with her that's up to them (hospice)."

On 6/10/2016 at 2:30 PM, E2, Director of Nursing (DON) stated, "I expect my staff to coordinate

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F 309	Continued From page 5 care with hospice."	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide and assess for the need for incontinent care and assist with hand hygiene after toileting for 4 of 9 residents, (R1, R3, R7 and R12) reviewed for incontinence and toileting needs in the sample of 15. Findings include: 1. The Minimum Data Set (MDS), dated 6/02/2016, documents R3 is moderately impaired with cognition and requires extensive assistance for personal hygiene and toileting. On 6/07/2016 at 12:45 PM, E16 and E17, Certified Nurse's Aides (CNA) transferred R3 from the wheelchair to the toilet. R3's incontinent brief was soiled with urine and was removed by E16. R3 urinated again while on the toilet. R3 smelled strongly of urine. R3 wiped her perineal area with toilet paper several times. E17 applied a new incontinent brief to R3 and pulled up R3's pants. Both E16 and E17 transferred R3 back into the wheelchair, then into bed. E16 and E17 did not prompt or assist R3 to wash her hands.	F 312		

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R3's Care Plan, dated 3/10/2016, documents, in part, "I am at risk for skin breakdown. I require assist with personal needs, which places me at an increased risk for skin breakdown."

2. The MDS, dated 4/19/2016, documents R12 requires extensive assistance with toileting and personal hygiene needs.

On 6/09/2016 at 10:47, E16 and E18, CNA, assisted R12 from the wheelchair to the toilet. R12's incontinent brief was dry, but R12 had a slight urine odor. R12 urinated on the toilet. R12 used her right hand to wipe herself with toilet paper. Both CNA's assisted R12 to stand and pull up the brief and pants, then transferred R12 back into the wheelchair. E18 pushed R12's wheelchair into the dining room for lunch at 10:59 AM. Neither E16 nor E18 prompted or assisted R12 to wash her hands after using the bathroom.

R12's Care Plan, dated 5/22/2016, documents, in part, "I have limited physical mobility related to weakness and dementia. I have a pressure ulcer on my coccyx related to immobility. I have mixed bladder incontinence related to physical limitations and use/side effects of medication, Lasix (a diuretic)." R12's Care Plan does not document issues with hand washing after toileting.

The facility's policy and procedure, dated 8/1996, and entitled, "Activities of Daily Living' documents, in part, "Facility staff will allow residents to care for themselves as able, teaching appropriate techniques for ADL's (activities of daily living). PURPOSE: To provide assistance to residents daily life functions, to supervise resident

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activities in order to maintain optimum function as long as possible and/or re-educate resident in techniques of daily life functions." The ADL policy has no documentation related to residents hand washing.

The facility's policy and procedure, undated and entitled, 'Incontinence Care' documents, in part, "All incontinent residents will receive incontinence care. PURPOSE: To keep skin clean, dry and free from irritation and odor and to identify skin problems as soon as possible so treatment can be started. Wash all soiled areas and dry very well, especially between skin folds. (May use soap and water or peri-care (perineal) incontinence spray)."

3. R7's MDS, dated 3/8/16 documents, in part, R7 requires extensive assistance of 1 staff for hygiene and extensive assist of 2 staff for toileting.

On 6/8/16 at 9:45 AM, E9 CNA, assisted R7 with toileting. R7 had a small amount of brown fecal matter in his adult brief. When R7 finished using the toilet, he wiped his own rectal area. E9 and E10, CNA, assisted R7 into the wheelchair. E9 then took R7 out to attend church. At no time did E9 or E10 offer to assist R7 with hand washing.

On 6/9/16 at 11:15 AM, E2, Director of Nurses (DON), stated, "Staff should assist residents with hand washing after using the restroom."

4. R1's MDS dated 3/8/2016 documents R1 has a diagnosis of Dementia and has severe cognitive impairment. The MDS documents that R1 requires extensive assistance of staff with activities of daily living and R1 is frequently

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F 312	Continued From page 8 incontinent. R1's Care Plan with revision date of 6/1/2016 documents in part, "Incontinent: check at least every 2 hours and as required for incontinence." On 6/8/2016, at 8:30 AM, R1 was sitting in a wheelchair in her room. At 8:45 AM, R1 remained in the wheelchair in her room and wanted to go "out there" to sit. When asked who could take R1 to the dining room/lounge area, E1 Administrator, said that she would take R1 into the area. On 6/8/2016 R1 remained in the wheelchair in the lounge area from 9:00 AM until 10:52 AM based on 15 minute or less observation intervals. At no time, did staff check R1 for incontinence. On 6/8/2016 at 10:52 AM, E14 and E15, CNAs, transferred R1 using a gait belt to her recliner without checking R1 for the need for incontinence care. On 6/8/2016 R1 remained in the recliner from 10:55 AM until 1:16 PM based on 15 minute or less observation intervals. At no time did any staff check R1 for incontinence. On 6/8/2016 at 1:27 PM, E14 removed R1's adult brief. E14 confirmed that R1's incontinent brief was fairly wet and that R1's perineal area was very red from the labia area throughout her inner thighs to her buttock area. On 6/8/2016 E2, Director of Nurses, (DON), said that she would expect staff to perform incontinence care as needed, at least every two hours. E2 also said that it is expected for staff to check incontinence when transferring a resident	F 312		

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F 312	Continued From page 9 from a wheelchair to a recliner. The facilities Policy on Incontinence Care undated documents in part, "Note: take all incontinent residents to the bathroom or put on the bedpan (unless contradicted) before and after meals and a (least) every two hours between meals, the bedpan should be offered at (least) every between meals."	F 312		
F 314 SS=G	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 implement interventions to prevent the formation of a pressure ulcer and ensure a dressing was in place for one of five residents (R12) reviewed for pressure ulcers in the sample of 15. This failure resulted in R12 developing a facility acquired Stage III pressure ulcer to her sacrum. Findings include: R12's Physician's Orders (PO) for 6/2016 document diagnoses, in part, as Alzheimer's	F 314		

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Disease, Cerebral Vascular Disease and Rheumatoid Arthritis. The Minimum Data Set (MDS), dated 4/19/2016, documents R12 is severely impaired with cognition, requires extensive assistance with bed mobility and is occasionally incontinent of urine.

The Braden Scale, dated 2/01/2016 documents R12 is at risk for skin breakdown.

The facility's Weekly Skin Report for 5/08 to 5/14/2016 documents, R12 has a facility acquired on 5/13/2016, Stage II to the sacrum measuring, 1.0 centimeter (cm) by (X) 1.5 cm X 0.1 cm. The interventions documented on the report are pressure relieving mattress and wheelchair cushion. Treatments for the ulcer are documented as wound gel and (foam dressing).

The facility's Weekly Skin Report, dated from 5/22/2016 to 5/28/2016, documents R12 now has a Stage III pressure ulcer to the sacrum, measuring 0.8 cm X 0.6 cm X 0.3 cm. Interventions are documented as pressure relieving mattress and wheelchair cushion. The intervention is Santyl.

A PO for R12, dated 5/23/2016, documents "Keep legs elevated when possible. (Special wound consultant) to consult and treat." The Wound Care Report, dated 5/25/2016, from Z2, Wound Consultant documents, in part, "well nourished 99 year old female, new pressure ulcer, of sacral region, Stage III, 0.8 cm X 0.6 X 0.3 cm X 0.48 cm, minimal necrotic tissue, scant serosanguinous drainage. Complicating factors include fecal and urinary incontinence at times."

On 6/09/2016 at 9:40 AM, R12 was sitting in a

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recliner in the day area, in a reclined position. On 6/09/2016 at 10:12 AM and 10:30 AM, R12 was sitting in the wheelchair. At 10:47 AM, E16 and E18, Certified Nurses Aides (CNA) transferred R12 from the wheelchair to the toilet. R12 had been incontinent of bladder and smelled of urine. A folded incontinent pad was on top of the pressure relieving cushion resting in the wheelchair seat, inhibiting the pressure relieving effect of the cushion. R12 had no dressing to the sacral area. After toileting, R12 was transferred back to the wheelchair and taken into the dining room for lunch at 10:52 AM.

On 6/09/2016 at 1:29 PM and 1:40 PM, R12 was in bed turned to the right side with a pillow behind her back. The head of the bed was elevated 30 degrees and her lower extremities were raised with a vinyl covered foam lift cushion. There were no side rails on R12's bed. At 1:41 PM, E19, Licensed Practical Nurse, (LPN) and E4, LPN assisted R12 to turn further to the right side. There was no dressing to R12's sacral area. R12 could not reposition herself. At that time, E19 reported R12 should have had a dressing to her pressure ulcer. E19 stated, "I don't know what happened to it. It looks about the same as last week." A small open area was on R12's sacral area.

On 6/09/2016 at 1:50 PM, E4 stated, "I don't know how (R12) got the wound."

On 6/10/2016 at 9:00 AM E2, Director of Nursing (DON) reported R12 likes to lay on her back.

R12's Care Plan, dated as revised on 5/24/2016, documents, in part, "I have a pressure ulcer on my coccyx related to immobility. Date initiated:

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F 314	Continued From page 12 5/23/2016. I need extensive assistance of 2 staff to turn/reposition at least every 2 hours. More often as needed or requested. I require the bed as flat as possible to reduce shear. When I need the head of the bed to be elevated, elevate the foot of the bed as well to prevent me from sliding. Instruct me to shift weight in W/C (wheelchair) every 15 minutes. Place a pressure reducing cushion on the w/c seat. Place a pressure reducing mattress on my bed. Date initiated: 5/23/2016." R12's Care Plan fails to document any refusal or noncompliance with turning or repositioning. R12's Nurses Notes for May and June 2016 has no documentation of refusal to off load pressure to the sacral area when attempted or asked. The facility's Pressure Ulcer policy and procedure, dated 8/1997, documents, in part, "A resident who enters the facility with or without (even when the individual's clinical condition demonstrates that they are unavoidable) pressure ulcers will be assessed, and given treatment to prevent the development of ulcers or treated to prevent further development of ulcers. The intent of this policy is to provide assessment and treatment of a resident to prevent the resident from developing a pressure ulcer; unless clinically unavoidable. The facility will provide care and services to: Promote the prevention of pressure ulcer development."	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318		

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range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide restorative services according to residents care plan for 2 of 13 residents (R2 and R10) reviewed for restorative services in a sample of 15.

Findings include:

1. R10's Minimum Data Set (MDS), dated 5/13/16, documents R10 has no cognitive impairment.

R10's Physician's Order Sheet (POS) dated 6/9/16, documents in part, "(R10) admit to (hospice) with terminal diagnoses dementia, CVA (cerbrovascular accident), and chronic kidney disease."

R10's POS, dated 6/9/16, documents in part, "Diagnoses of presence of artificial wrist joint, unspecified osteoarthritis, contracture unspecified joint, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side."

R10's Hospice contract in medical record documents hospice services began 5/4/16.

On 6/9/16 at 9:22 AM, E22, Restorative Aide, stated, "(R10) is on hospice. We do not do any passive range of motion with her any more."

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On 6/9/16 at 12:15 PM, E4, Licensed Practical Nurse (LPN)/Care Plan Nurse, stated, "(R10) is no longer on restorative program but might get gentle bedside range of motion as part of her care. She also no longer wears braces to her knees for contractures."

On 6/9/16 at 3:50 PM, E4 stated "All the care plans are up to date and correct."

On 6/10/16 at 11:22 AM, E4 stated, "We don't have a restorative flowsheet for (R10) for May (2016). We stopped (R10's) restorative treatment the end of April (2016).

R10's Care Plan, dated 4/23/16, documents in part, "Restorative Programs - Invite/escort me to the AM group session every morning. Encourage me to participate every day. Provide me with set up of any equipment I may need to perform all ranges. Instruct me to perform at least 10 reps (repetitions) with each joint. Assist me with verbal/physical cues as needed. Stop ranges if I complain of pain. Assess my range of motion routinely. Provide me with rest periods as needed. Encourage me to participate to my full potential. Notify the nurse if I continue to complain of pain or if I develop decreased ROM (range of motion). Provide a referral to Skilled therapy as needed. Document and participation and performance."

R10's Restorative Nursing Flow Sheet, dated April 2016, documents no restorative treatment provided for 4/26/16, 4/27/16, 4/28/16, 4/29/16, 4/30/16. There were no Restorative Nursing Flow sheet for May or June 2016 in R10's medical record.

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F 318	Continued From page 15 2. R2's MDS documents R2 is cognitively intact. R2's POS, dated 1/30/2015, documents in part, "May have restorative services." R2's POS, dated 6/9/16, documents in part, "diagnoses - primary generalized osteoarthritis, generalized muscle weakness." On 6/7/16 at 11:40 AM, R2 was unable to feed herself. At the same time, R2's husband held the cup with a straw so that R2 could drink. R2 was fed her lunch meal by staff. On 6/8/16 at 8:28 AM, R2 fed herself toast. Staff folded and placed toast in R2's contracted hands. On 6/7/16 at 1:10 PM, R2 stated, "I get exercises on my hands and feet. I can't walk, but they don't come every day." On 6/8/16 at 10:43 AM, E23, Restorative Aide, asked R2 if she could do exercises with her. E23 lifted R2's left forearm and moved forward and back at elbow four times, then moved R2's forearm up and down four times, the moved sideways back and forth four times. E23 then moved R2's left wrist back and forth four times, then up and down four times, then rotated wrist four times. At 10:45 AM, E23 stated, "Does that hurt (to R2)?" R2 responded"Oh, so so." At that time, E23 stopped exercises on that arm. At 10:47 AM, E23 lifted R2's left lower extremity bending at R2's knee four times. Then E23 lifted R2's right lower extremity bending at R2's knee four times. E23 then rotated R2's right ankle twice. At 10:48 AM, E23 stated to R2, "Does that hurt?" R2 stated to E23, "No that feels good." At 10:50 AM, E23 rotated R2's left ankle twice. E23 then washed her hands and left the room. E23	F 318		

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did not perform ROM on R2's following joints/ Planes: Horizontal Abduction and Adduction of the Left Shoulder; Flexion, Extension, Abduction and Adduction of the fingers on both R2's Right and Left Hands; Abduction and Adduction and Internal and External rotation of R2's Left and Right Hip; Dorisflexion and Planter Flexion of R2's Left and Right Ankle; Flexion, Extension, Abduction and Adduction of R2's toes on both feet.

On 6/8/16 at 10:52 AM, E23 stated, "I should have done all the joints and I didn't do her hands."

On 6/9/16 at 12:15 PM, E4 stated, "(R2) needs restorative exercises to decrease pain and further contractures. We provide (R2) with rest periods during exercises. I would expect the restorative aides to following the policy."

On 6/9/16 at 3:50 PM, E4 stated "All the care plans are up to date and correct."

R2's current care plan revision date 4/20/15, documents in part, "I have limited physical mobility (related to) osteoarthritis, contractures, and weakness. I require extensive assist with all activities of daily living. My main mode of mobility is per wheelchair. I will remain free of complications related to immobility, including contractures, through the next review date. Target date 8/11/2016. Interventions: nursing restorative: Passive (range of motion) program #1 I already have contractures to my shoulders, bilaterally. Please encourage me to participate every day. Remind me of my goal if I refuse. I will need you to perform passive (range of motion) to all my joints, upper and lower extremities. Stop ranges if I complain or show

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(signs and symptoms) of pain. I tire easily. Provide rest periods as needed. Assess my ranges routinely and notify the nurse if I display decreased ranges."

The facility's "Contracture Prevention" policy dated 3/8/2013, documents in part, "Procedure 13. d. "Encourage and assist resident to perform passive and active exercises to maintain and improve strength, maintain and restore joint function, prevent deformities, stimulate circulation and build endurance."

The facility's "Range of Motion" policy dated 3/8/2013, documents in part, "Policy: Range of motion exercises will be implemented for all residents in need and/or as physician orders. Purpose: To move the resident's joints through as full a range of motion as possible, to improve or maintain joint mobility and/or to prevent contractures. Finger and Thumb:
Extension/Flexion:
1. Keep in arm the same position as for forearm exercises.
2. Grasp palm and wrist with one hand and gently straighten the=fingers with the other (Extension).
3. Place your hand on the back of the resident's fingers and gently bend hand into fist (flexion).
4. Repeat these two motions with each finger, individually flexing each joint.
Abduction/Adduction:
1. In the same position as for extension/flexion, spread two adjacent fingers apart (Abduction).
2. Bring fingers back together (adduction).
3. Repeat this exercise for all fingers and thumbs.
Opposition:
In the same position as for extension/flexion,

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pinch the thumb and fingertip together, one at a time.
Hip and Knee:
Extension/Flexion:
1. With the resident's leg flat on the bed in the natural, extended position, place one hand under the ankle and the other hand under the knee.
2. Bend the hip and knee under the chest, sliding your hand out from under the knee to all full joint flexion.
Abduction/Adduction:
1. Place your hands under the ankle and knee and move the leg from side out and away from the other leg (abduction)
2. Move leg back toward midline over and across the midline, if possible (abduction).
Internal/External Rotation:
1. With the resident's leg flat on the bed, grasp back of leg just above the ankle and at knee.
2. Roll the leg toward the midline (internal rotation)
3. Roll leg away from the midline (external rotation)
Ankle:
Dorsiflexion/Plantar Flexion:
1. Place one hand under the heel and the other hand on the ball of the foot.
2. Push the foot toward the head and pull the heel back (dorsiflexion).
3. Move hand from the ball of the foot to the top of the foot and pull the foot down toward the bed.
Foot:
Inversion/Eversion:
1. Maintaining the starting position as for ankle circumduction, hold the ankle securely.
2. Turn the foot with the sole toward the midline (inversion).
3. Turn the foot away from the midline (eversion).
Toes:

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F 318	Continued From page 19 Extension/Flexion: 1. Hold the ankle securely with one hand and curve the toes toward the sole the other hand (flexion). 2. Straighten and stretch the toes back toward the top of the food (extension)."	F 318		
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 interview, observation and record review, the Facility failed to safely transport residents in wheelchairs to prevent accidents/falls for 1 of 6 residents (R7) reviewed for falls in the sample of 15. Findings include: R7's Physician's Order Sheet, dated June 2016, documents he has diagnoses of Parkinson's Disease and Lewy body disease. R7's Incident Reports, dated January 2016 to present, were reviewed and documents R7 has had multiple falls. R7's Minimum Data Set (MDS) dated 3/8/16 documents, in part, R7 requires extensive assistance of 1 staff member for locomotion in	F 323		

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F 323	Continued From page 20 the wheelchair. R7's Minimum Data Set documents he is at risk for falls. R7's Incident Report, dated 5/7/2016, at 3:50 PM documents, in part, "CNA (Certified Nurse's Assistant) assisting resident from shower to resident's room, resident was in W/C (wheelchair). CNA was pushing W/C, while resident was also using legs to propel W/C. Resident fell forward out of W/C onto floor. Hit head on floor. Complete body assessment done. Assisted up in W/C with use of gait belt and 3 staff. 3 cm (centimeter) gash to right forehead, steri-strips applied. 1 cm skin tear to Right elbow area, steri-strips applied. Small skin tear to top of left foot 0.5 cm X 0.5 cm band- aid applied. VS (vital signs) 98.8 - 64-20-154/60 Neuro (neurology) checks initiated. Notes: CNA's educated to allow (R7) to propel the w/c himself when able and if they are to propel for him, to apply leg rests." R7's "Temporary Care Plan", dated 5/7/16, at 3:50 PM documents, in part, "Educate my CNA's to allow me to propel myself when I can. If the CNA's needs to propel myself when I can. If the CNA needs to propel the w/c for me, to place foot pedals on my w/c." R7's Incident Report, dated 6/6/2016, at 8:20 PM documents, in part, "Notes: (R7) was being assisted by a Unit Aide from the nurses station to the common area, he put his feet down which caught the fall and cause him to fall out of the w/c. Staff in-serviced while assisting with locomotion, place bilateral foot rest on w/c and remove once destination is reached." R7's "Temporary Care Plan" dated 6/6/16 untimed	F 323		

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F 323	Continued From page 21 documents, in part, "Staff inserviced-while assisting with locomotion place B (bilateral) foot rests on w/c and remove once destinations is reached." On 6/8/16 at 9:20 AM, E5, CNA, propelled R7 to his room without foot pedals. On 6/9/18 at 10:15 AM, E4, Licensed Practical Nurse (LPN), stated, "Yes. (R7) should have foot pedals on his wheelchair when staff are propelling him. It was a good idea but it never got fully implemented.	F 323		
F 325 SS=D	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 (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 implement dietary recommendations/interventions to address an insidious weight loss for one of eleven residents (R11) reviewed for nutritional risk in the sample of 15.	F 325		

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Findings include:

On 6/9/2016, at 12:09 PM, R11 was being fed lunch by his wife. E20, Registered Nurse, (RN), put a cup of liquid on the tray. E20 confirmed that the liquid was a liquid dietary supplement and the amount was 60 cubic centimeters (cc.). E20 also confirmed that the medication administration record documents the liquid dietary supplement to be give 60 cc three times per day.

R11's Minimum Data Set, (MDS), dated 4/16/2016 documents a Diagnosis of Alzheimer's Disease. It also documents that R11 has severe cognitive impairment and requires extensive assistance for eating.

R11's Electronic Medical Records, dated 10/20/15, documents height of 69 inches. The monthly weight report documents R11 weighed 128.4 pounds (lbs.) in April 2016, 123 lbs. in May 2016 and 121.8 lbs. in June 2016.

R11's Nutritional/ Dietary note, dated 4/5/2016, document in part, "weight down 17.4 pounds, (lbs.) in three months, and down 28 lbs. in 6 months."

R11's Nutritional/ Dietary note, dated 4/27/2016, documents in part, "Notified family member of weight loss. He stated that (R11) needs to be fed when wife not here for meals."

R11's Nutritional/ Dietary note, dated 5/17/2016, documents in part, "Requires staff assist with meals. Diet recently down graded to pureed due to chewing textured foods for a long time. Intake appears to have gotten better with pureed consistency. Weight: (5/12) 123 lbs. down 5 lbs in

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F 325	Continued From page 23 one month, down 12.4 lbs in three months, and down 27 lbs. in six months. Recommend increase med pass 2.0 90 milliliters (ml) three times a day." R11's nutritional recommendations, dated 5/17/2016, and signed by physician on 5/18/16 does not document recommendation of dietary supplemental liquid to be increased to 90 cc three times a day. On 6/9/2016 at 1:30 PM, E11, Dietary Manager, and E2 Director of Nurses, both confirmed that it was the responsibility of the dietician who recommended the liquid dietary supplement to be increased on 5/17/2016 to be transcribed to the nutritional recommendation sheet that is sent to the physician. The Facilities Policy C-13, undated, documents in part, " 5.3 Per facility, designated personnel should notify the physician of the weight loss and document the notification in the patients chart. 5.4 The dietary manager/assistant dietary manager will place the patients with significant weight loss on the Dietitian Referral list for review at the next visit. 5.5 The dietitian will evaluate and document in the medical record the weight loss and nutritional intervention, if applicable."	F 325		
F 441 SS=E	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 24 (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 interview, observation and record review, the Facility failed to use proper hand hygiene, offer hand hygiene and change gloves to prevent cross contamination or spread of infection for 4 of 13 residents (R3, R5, R7, R12) reviewed for infection control in the sample of 15.	F 441		

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Findings include:

1. On 6/8/16 at 8:36 AM, E13 Certified Nurse's Aide (CNA), removed the wet incontinent brief from R5. E13 donned gloves, washed R5's pubic area and penis with the same gloves. Each time E13 obtained a new wash cloth, she would hold the multiuse spray periwash bottle and spray the periwash onto the wash cloth with the soiled gloves. E13 finished washing R5's pubic area and his penis and then used the same soiled gloves for drying the areas. R5 was rolled over, and E13's washed R5's right buttock with the same gloves and the same technique for spraying the periwash onto the wash clothes. E13 removed the gloves, reached in her pocket, got a new pair of gloves, donned gloves and applied barrier cream. E13 removed gloves and assisted R5 with getting dressed.

On 6/8/16 at 8:50 AM, E13 stated, "The periwash bottle is multiuse it is kept on our cart."

2. R7's Minimum Data Set (MDS) dated 3/8/16 documents, in part, that R7 requires extensive assist of 1 staff member for hygiene and extensive assist of 2 staff members for toileting.

On 6/8/16 at 9:45 AM, E9, CNA assisted R7 with toileting. R7 had a small amount of brown fecal matter in his adult brief, and the brief was wet with urine. When R7 finished using the toilet, he wiped his own rectal area.E9 cleansed R7's buttocks area. E9 removed her gloves but did not wash her hands. E9 and E10 then assisted R7 with dressing and transferred to him to the wheelchair. E9 then took R7 out to attend church. At no time did E9 or E10 offer to assist R7 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. BUILDING ______ B. WING ______	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVISTON COUNTRYSIDE MANOR	450 WEST 1ST STREET AVISTON, IL 62216

(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
F 441	Continued From page 26 hand washing. On 6/9/16 at 11:15 AM, E2, Director of Nurses (DON), stated, "Staff should assist residents with hand washing after using the restroom. Staff are expected to sanitize hands after removing gloves. Staff should not touch items with soiled gloves." 3. The MDS, dated 6/02/2016, documents R3 is moderately impaired with cognition and requires extensive assistance for personal hygiene and toileting. On 6/07/2016 at 12:45 PM, E16 and E17, Certified Nurse's Aides (CNA) transferred R3 from the wheelchair to the toilet. R3's incontinent brief was soiled with urine and was removed by E16. R3 urinated again while on the toilet. R3 smelled strongly of urine. R3 wiped her perineal area with toilet paper several times. E17 applied a new incontinent brief to R3 and pulled up R3's pants. Both E16 and E17 transferred R3 back into the wheelchair, then into bed. E16 and E17 did not prompt or assist R3 to wash her hands. 4. The MDS, dated 4/19/2016, documents R12 requires extensive assistance with toileting and personal hygiene needs. On 6/09/2016 at 10:47, E16 and E18, CNA's, assisted R12 from the wheelchair to the toilet. R12's incontinent brief was dry but R12 had a slight urine odor. R12 urinated on the toilet. R12 used her right hand to wipe herself with toilet paper. Both CNA's assisted R12 to stand and pull up the brief and pants, then transfer R12 back into the wheelchair. E18 pushed R12's wheelchair into the dining room for lunch at 10:59 AM. Neither E16 nor E18 prompted or assisted R12 to	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. BUILDING ______ B. WING ______	06/10/2016

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F 441	Continued From page 27 wash her hands after using the bathroom. The facility's policy and procedure, dated 10/2004 and entitled, "'Handwashing" documents, in part, "Facility staff will follow proper hand-washing techniques at all times. PURPOSE: To prevent the spread of bacteria and disease and to provide a clean, healthy environment for residents and staff. Hand washing is the most important procedure in preventing the spread of disease and infection." The facility's policy and procedure, dated 6/1996 and entitled, "Infection Control, Standard Precautions" documents, in part, "Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin. Change gloves between tasks and procedures on the same resident, after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated and environmental surfaces, and before going to another resident."	F 441		