



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

November 15, 2016

Joseph Rudd, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **October 21, 2016**, a survey was conducted at Apex Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 28, 2016**. Failure

to submit an acceptable PoC by **November 28, 2016**, may result in the imposition of civil monetary penalties by **December 17, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 21, 2017**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

Joseph Rudd, Administrator  
November 15, 2016  
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If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **November 28, 2016**. If your request for informal dispute resolution is received after **November 28, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



David Scott, RN, Supervisor  
Long Term Care

Joseph Rudd, Administrator  
November 15, 2016  
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DS/lj

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>
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(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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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from October 17, 2016 to October 21, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Teresa Kobza, RDN/LD Beverly Briggs, RN Nina Sanderson, LSW Susan Costa, RN Edith Cecil, RN</p> <p><b>ABBREVIATIONS and DEFINITIONS:</b></p> <p>A-Fib = Atrial Fibrillation ADL = Activities of Daily Living AIT = Administrator in Training BG=Blood Glucose BID = Twice a day BIMS = Brief Interview for Mental Status BKA=below the knee amputation BLE = Bilateral Lower Extremities Braden score = (used to determine a person's risk to develop pressure ulcers) BUE = Bilateral Upper Extremities CAA = Care Area Assessment C-DIFF=Clostridium Difficile CHF = Congestive heart failure CM = Centimeters CNA = Certified Nursing Assistant CVA = Cerebrovascular accident (stroke) DC'D = Discontinued DM = Diabetes Mellitus DNR = Do Not Resuscitate DNS = Director of Nursing Services</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>11/28/2016</b>
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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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F 000	Continued From page 1 EMR = Electronic Medical Record ER=Emergency Room FTT = Failure to Thrive GDR = Gradual Dose Reduction GI - Gastrointestinal GERD = Gastroesophageal Reflux Disease etc = Etcetera HS = bedtime HTN = Hypertension (high blood pressure) hx = History IDT=Interdisciplinary Team LN = Licensed Nurse LPM = Liters per minute LPN = Licensed Practical Nurse LSW = Licensed Social Worker LTC = Long Term Care LW = Laundry Worker MAR = Medication Administration Record MD = Physician MDS = Minimum Data Set MG = Milligram(s) mL=Milliliter MI - Myocardial infarction (heart attack) NC = Nasal cannula NN=Nursing note O2 = Oxygen OT = Occupational Therapy PHQ-9 = Patient Health Questionnaire P&P = Policy and Procedure(s) POA = Power of Attorney POST = Physician Orders for Scope of Treatment PRN = As needed PPE = Personal Protective Equipment PROM = Passive Range of Motion PT = Physical Therapy PU = Pressure Ulcer RD = Registered Dietician RN = Registered Nurse	F 000			

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F 000	Continued From page 2 RNA = Restorative Nursing Assistant ROM = Range of motion RNP = Restorative Nursing Program R/T=Related to SI =Suicidal Ideations SIC = Skin Integrity Coordinator SOPA=Sol Oasis Program Assistant SOPD=Sol Oasis Program Director Tab(s) = Tablet(s) TAR = Treatment Administration Record TV = Television TEN=Treatment Encounter Note UDA = User defined assessment UM = Unit Manager w/c = Wheelchair	F 000			
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156		12/14/16	

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F 156	<p>Continued From page 3</p> <p>other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure posted patient rights information included the name and telephone number of the State Agency to whom patients could report complaints, fraud and abuse. This failure to provide State Agency contact information affected all 78 residents in the facility. Findings include:</p> <p>During a tour of the facility on 10/21/16, beginning at 8:40 am, a bulletin board across from the conference room in the west wing included an 8 inch by 11 inch paper that stated "Abuse Prohibition Policy." The information</p>	F 156	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p>		

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F 156	Continued From page 5 included the facility policy, and to whom in the facility alleged or suspected violations were to be reported to. The posted paper also included agencies to contact which included the State Agency of Bureau of Facility Standards. The posting of this information was in the lower right hand section, and was not prominently displayed for residents.  10/21/16 at 10:00 am, the facility Director of Maintenance reviewed the posted information and stated "That's not where I'd look for that."  The facility did not ensure the State Agency information for residents was posted in a prominent location that was easy to access and read.	F 156	F156 Inform of Services  1) In addition to the phone number for the Bureau of Facility Standards that was already posted on the Center's abuse prohibition notice; the address of Facility Standards was posted at wheel chair height by Center Executive Director on or 10/21/16. The posting was reviewed by the survey team prior to exiting the building and determined to be acceptable.  2) All Residents have the potential to be affected by not having the address with which to visit the Bureau.  3) The updated abuse prohibition notice, which includes contact information for advocacy groups, was presented in the resident council meeting on 11/3/16 and again on 11/22/16 to educate residents regarding the updated contact information.  4) Monthly, the center administrator will review the posted contact information for advocacy groups, to ensure it is current and accurate. The results of that review will be presented in the center's QAPI meeting for three months, beginning in December 2016.		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written	F 226		12/14/16	

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F 226	<p>Continued From page 6</p> <p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to ensure all contract staff working unsupervised with residents were trained on how and to whom suspicion of abuse should be reported within the facility. The failure created the potential for all resident to experience ongoing abuse and neglect within the facility. Findings include:</p> <p>The facility's Abuse Prohibition policy, revised on 9/1/16, documented "will prohibit abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property for all patients through training of employees, both new and ongoing training for all employees. The policy did not address contract staff working unsupervised while providing services with in the facility.</p> <p>On 10/21/16 at 8:10 am, a contract housekeeper stated she had not received abuse training from the contracted facility. She stated she had received training at a previous facility workshop. She did not know what catastrophic reactions were. She stated she would report abuse to the administrator and named the AIT.</p> <p>On 10/20/16 at 2:00 pm, a contract housekeeping employee stated he received abuse training 3 years ago. When asked what he would do if he observed someone being abused,</p>	F 226	<p>F226 Staff Treatment of Residents</p> <p>1) Current contract staff used in the center completed the center's abuse prohibition training on or before 12/12/16 by the center administrator.</p> <p>2) Failure of contract staff understanding the center's abuse prohibition policy has the potential to affect all residents. Residents, in resident council, were educated regarding the center's abuse prohibition policy by the LSW on or before 11/3/16.</p> <p>3) Prior to beginning work, contract staff will receive Center's Abuse Prohibition training, and annually. The Center HR Coordinator will be responsible for maintaining files of such training and validating that it is occurring prior to contract staff working. Education provided to contract staff managers regarding this expectation.</p> <p>Beginning the week of 11/28/16 for 4 weeks and then monthly for two months five contract employees will be queried on their knowledge of the abuse prohibition policy. With education provided as</p>		

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F 226	Continued From page 7 he stated he "would grab a nurse, let them know. You need a witness, then they know you are telling the truth."	F 226	needed.		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the Resident Rights in the facility's Welcome Pack, it was determined the facility failed to ensure the dignity of 1 of 15 sample residents (#4), 8 random residents (#19, #20, and #22-#27) and six unidentified residents, was promoted and maintained. The failures created the potential for a negative effect on the residents' psychosocial well-being when: a) residents were not given an opportunity to respond when staff entered their rooms without knocking or staff knocked as they were already entering the room; b) a "sore" on Resident #19's arm was examined in front of other residents; c)	F 241	241 Dignity  1) 6 unidentified residents queued for meds  Resident # 4 was assessed by LSW or designee on or before 11/30/16 regarding dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were identified.  Resident # 22 was assessed by LSW or designee on or before 11/30/16 regarding	12/14/16	

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F 241	<p>Continued From page 8</p> <p>Resident #20 was not fully covered during transport from a shower room; d) in a loud voice and halfway down the hall, a staff member told Resident #27 to push his call light; and e) six residents were lined up by a medication cart waiting for medications. Findings include:</p> <p>1. During a random observation by the East Nurses' station, on 10/20/16 at 7:00 am, LN #2 was administering medications to 6 unidentified residents in wheelchairs. The residents were lined up in a row and moved forward one at a time by staff as it became their turn for medication administration. Unidentified staff then moved these residents into the dining room. When CNA #1 was questioned about this process, she said that "they (residents) get their medications and then are moved to the Dining Room." LN #2 started to administer eye drops to an unidentified resident, in the presence of four other residents and three staff, but the DNS approached LN #2 and told her not to administer medications in the common area.</p> <p>2. The facility's Welcome Pack contained "Information and Rights for Patients and Residents" which documented, "...privacy in accommodations... Discussions about your care, examination and treatment are confidential and will be conducted discretely...[and] You have the right to privacy in your room. Center staff will respect this right by first knocking on the door before entering your room."</p> <p>Staff were observed entering residents' rooms without knocking or knocking briefly on the door while in motion going into the room as follows:</p>	F 241	<p>dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were identified.</p> <p>Resident # 23 was assessed by LSW or designee on or before 11/30/16 regarding dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were identified.</p> <p>Resident # 24 was assessed by LSW or designee on or before 11/30/16 regarding dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were identified.</p> <p>Resident # 25 was assessed by LSW or designee on or before 11/30/16 regarding dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were identified.</p> <p>Resident # 26 was assessed by LSW or designee on or before 11/30/16 regarding dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were identified.</p> <p>Resident # 27 was assessed by LSW or designee on or before 11/30/16 regarding dignity concerns related to staff entering their rooms without knocking or entering while knocking. No concerns were</p>		

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F 241	<p>Continued From page 9</p> <p>a. On 10/17/16 at 1:28 pm, CNA #2 entered Resident #4's room without knocking and CNA #3 quickly knocked twice on the door while in motion going into the room behind CNA #2.</p> <p>b. On 10/18/16 at 9:45 am, CNA #6 knocked quickly while in motion going into the room of Residents #26 and #27. At 9:55 am, CNA #6 said she did knock while in motion entering the residents' room.</p> <p>c. On 10/20/16 at 8:00 am, RN #2 entered Resident #4's room without knocking. At 8:20 am, RN #2 said she did not knock before entering the resident's room.</p> <p>d. On 10/17/16 at 2:16 pm, CNA #2 was giving report to CNA #3 and walked into the room of Resident #25 and #27 without knocking. The CNA's discussed the residents briefly and left. While giving report they also entered Resident #22, #23 and 24's room without knocking.</p> <p>3. On 10/21/16 at 11:50 am, Resident #19 was sitting in his wheelchair and asked LPN #1 to examine his arm because it was hurting. LPN #1 pulled up Resident #19's sleeve and exposed a raised blue/purple 1/2 inch sized lump. LPN #1 palpated Resident #19's arm around the raised area asking if it hurt and how long it hurt. She stated that the area did not look good, looked infected, and "gross." She stated she would look at it closer after lunch. There were two other residents present in the hallway when Resident #19's arm was examined.</p> <p>4. On 10/18/16 at 9:30 am, Resident #27 was in his room and called out for help. LPN #3 was</p>	F 241	<p>identified.</p> <p>Resident # 27 was interviewed by LSW for psychosocial concerns related to LN #3 response to his yelling for help rather than using his call-light. No concerns were identified.</p> <p>Resident # 20 had psychosocial assessment related to partial exposure during shower transport by center LSW on or before 11/30/16. Resident showed no adverse psychosocial effects at time of assessment.</p> <p>Resident # 19 had psychosocial assessment by LSW or designee on or before 11/30/16 for assessment of arm in public area. Resident showed no adverse psychosocial effects at time of assessment.</p> <p>2) Residents were audited for dignity concerns by facility managers on or before 11/30/16. Identified concerns were corrected at the time identified with appropriate staff education provided as indicated.</p> <p>3) Staff were reeducated, on or before 11/30/16 by the Center Nurse Executive of designee on the purpose and intent of 42 CFR 483.15(a); and provided instruction on how to identify resident issues/concerns related to this requirement.</p>		

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F 241	Continued From page 10 halfway down the hall and yelled out in a loud voice "Can't you push your call light?" LPN #3 continued to do what she was doing and the resident's call light did not go on. LPN #3 saw a CNA in the hall and asked them to assist Resident #27.  5. On 10/19/16 at 11:59 am, Resident #20 was wheeled out of the shower room in a shower chair. He had a blanket which covered most of his body. The blanket was not covering all of his right side, which was exposed about 2 inches up from the shower chair. His legs were also exposed from the knees down.	F 241	4) Beginning the week of 11/28/16 members of the center IDT will complete center rounds to ensure compliance with 42 CFR 483.15(a). Rounds will be completed 5 times weekly for 4 weeks; then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.  Results of the rounds will be presented in the center QAPI meeting for three months (or longer as necessary) beginning in December, with any identified negative trends addressed through system modification and staff education as appropriate.		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, and resident POA interview, and policy and record review, it was determined the facility failed to ensure residents had the right to a) choose activities, schedules, and health care consistent with his or her interests, assessments, and plans	F 242	242 Resident Determination/Choice  1) Resident #2 was interviewed by administrator in training for shower preference related to time and day of week. No concerns noted with current	12/14/16	

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F 242	<p>Continued From page 11</p> <p>of care; b) interact with members of the community both inside and outside the facility; and c) make choices about aspects of his or her life in the facility that are significant to the resident. This was true for 2 of 9 (#2 and #5) sampled residents. Resident #5 had potential for more than minimal harm when the facility placed greater restrictions than required per contact isolation policy and Resident #2 when staff did not adhere to her choices.</p> <p>1. Resident #5 was admitted to the facility on 9/6/16, with diagnoses including post right leg below the knee amputation [BKA], pressure ulcer to sacrum, depression, bipolar disorder, and Clostridium Difficile.</p> <p>A Care Plan dated 9/9/16, documented meaningful activities for Resident #5 included practicing his religion, being around animals, socializing with others, and spending time outdoors. Interventions included inviting him to programs of potential interests such as Pet group, Prayer and Share, Socials, special events, Healthier You, and chaplain visits. The care plan stated it was important to Resident #5 to go outside for fresh air in good weather and he should be provided access to outdoor areas.</p> <p>A Care Plan dated 9/8/16, documented he was at risk of complications of infection related to C-Diff. Interventions included antibiotic medication, assisting Resident #5 with handwashing as needed, educating him on good handwashing, and preventing the spread of infection.</p> <p>On 9/9/16 at 9:21 am, a nurses' note documented lab results for a stool sample as</p>	F 242	<p>schedule. Sleep monitor was put in place to track hours of sleep. Care plan was updated by IDT on or before 11/30/16. The resident and her representative were involved in the development of her care plan goals and interventions.</p> <p>Resident #5 was provided assistance to and from activities and meals and ADL support needs. Resident #5 is no longer on isolation precaution.</p> <p>2) Residents were interviewed on or before 11/30/16 by members of the IDT regarding their individual preferences, and whether their preferences were taken into consideration regarding their schedules. Residents who voiced concerns were referred to the RN Unit Manager for follow-up.</p> <p>3) The facility Infection Preventionist was educated by the Center Nurse Executive on or before 11/30/16 regarding the need to remain up to date on the status of precaution needs for each patient/resident with isolation precautions in order to ensure that the precautions are the least restrictive possible according the patient/resident's then current condition.</p> <p>Isolation Precautions will be communicated to both residents and their families to validate type and understanding of precautions including but not limited to leaving their rooms for activities, meals, and therapy.</p>		

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F 242	<p>Continued From page 12 positive for C-diff, and he was on contact precautions.</p> <p>The facility's Policy and Procedure for Contact Precautions, review date of 9/1/15, directed, "DO NOT restrict patient to his/her room."</p> <p>The facility's Policy and Procedure for C-diff, revised 7/1/14, included:</p> <ul style="list-style-type: none"> <li>* Maintain Contact Precautions for 48 hours after the diarrheal episodes stop, or the patient's stool returns to baseline.</li> <li>* Maintain stringent hand washing and explain precautions and proper handwashing to patients and visitors.</li> <li>* Patients may move around Center [facility] as long as fecal excretions can be contained and proper hand washing is maintained.</li> </ul> <p>A Care Plan meeting note, dated 9/9/16 at 3:05 pm, documented Resident #5 expressed an interest in getting outside when he was off isolation, as well as, having a deck of cards and coloring sheets for in-room leisure.</p> <p>An MDS assessment, completed on 9/13/16, documented Resident #5 was cognitively intact and required extensive assist of 2 staff for bed mobility, transfers, and toileting.</p> <p>An activity note, dated 9/15/16 at 4:40 pm, documented, "played a card game of Slap Jacks."</p> <p>A Social Service note documented by the LSW,</p>	F 242	<p>Residents care preferences schedule will be reviewed during quarterly care conferences, or upon request, to validate their personal preferences for days and times.</p> <p>Staff were educated by the CNE or designee, on or before 11/30/16 regarding the standard of compliance for 42 CFR §483.15(b).</p> <p>4) Beginning the week of 11/28/16 members of the center IDT will complete center rounds and resident interviews, to ensure compliance with 42 CFR §483.15(b). Rounds will be completed 5 times weekly for 4 weeks; then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time referred to a Center Nurse Manager for resolution.</p> <p>Results of the rounds will be presented by the CNE or designee in the center QAPI meeting for three months (or longer as necessary) beginning in December, with any identified negative trends addressed through system modification and staff education as appropriate</p>		

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F 242	<p>Continued From page 13 dated 9/18/16 at 5:05 pm, noted a Care Plan was initiated to address a possible decrease in Resident #5's psychosocial functioning.</p> <p>An Activity note, dated 9/23/16 at 4:27 pm, documented "played a card game of Slap Jacks with Resident #5."</p> <p>A Nurse Practitioner's Follow Up note, dated 10/5/16, documented, "According to staff, Resident #5 has had some behavioral issues, becoming quite agitated and verbally abusive to staff. The resident tells me when asked about this that he is very frustrated being in isolation due to C-Diff, and after discussion, he does feel his symptoms will improve once he is able to get up and out of his room."</p> <p>An Activity note, dated 10/8/16 at 2:37 pm, documented, "Played card games and chatted with Resident #5."</p> <p>An Activity note, dated 10/15/16 at 3:59 pm, documented, "played a card game of Slap Jacks with Resident #5."</p> <p>A nurses' note, dated 10/16/16 at 2:20 pm, documented Resident #5 continued on antibiotics for C-Diff. Loose stools, but no diarrhea, was noted. The note further stated Resident #5's stool did not smell like C-Diff anymore.</p> <p>On 10/17/16 at 10:50 am, the door to Resident #5's door was closed. A sign on the door directed visitors to check with a nurse prior to entering the room. At 1:10 pm, the door remained closed. Resident #5 stated the door was always closed. He stated he had not been out of his room except</p>	F 242			

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F 242	<p>Continued From page 14</p> <p>to go to appointments outside the facility. He said, "There is a lady that comes in and plays cards with me once in a while. I can't get out of bed by myself." Resident #5 reported that staff helped him get in his wheelchair when he was going out of the facility.</p> <p>During the same interview, Resident #5 reported that over the past two days his bowel movements had been normal and there had been no C-Diff smell. He stated that he could hold his bowel movements unless it took 45 minutes for staff to answer the call light and help him as he used a bedpan. He said, "They have me in a brief, just in case." Resident # 5 stated he enjoyed being around other people but could not because of "this disease."</p> <p>A Social Service note, dated 10/17/16 at 6:37 pm, documented that LSW educated Resident #5 that he would be utilizing coping skills through one-to-one visits while he was on C-Diff precautions.</p> <p>On 10/18/16 at 9:50 am, 10:20 am, and 1:15 pm, the door to Resident #5's room remained closed.</p> <p>On 10/20/16 at 10:00 am, Resident #5 stated he could leave the room now, as long as he had no feces on his hands. Resident #5 stated no one had asked him what his normal bowel movements were like.</p> <p>On 10/21/16 at 8:30 am, Resident #5 was sitting up in his wheelchair and the door to his room was open. He stated he, "attended group activities, it is good to be able to get out of this room."</p>	F 242			

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F 242	<p>Continued From page 15</p> <p>The facility did not provide transfer assistance needed to Resident #5 to be able to engage in his preferred activities on a routine basis. The facility placed greater restrictions on Resident #5's activity than their policy directed.</p> <p>2. Resident #2 was admitted to the facility on 10/8/13, with diagnoses that included major depression, anxiety disorder, dementia, and insomnia.</p> <p>Resident #2's record did not indicate she, or her POA, were provided choices related to promoting her sleep and times of grooming, such as bathing. This had the potential to result in a sense of devaluation, lack of control over ADL choices, and increased refusal of cares.</p> <p>a. Resident #2's care plan documented "Resident with sleep pattern disturbance as evidenced by Insomnia."</p> <p>The stated goal was, "The resident will demonstrate an optimal balance of rest and activity as evidenced by 6-8 hours of sleep per night."</p> <p>Interventions included, "Coordinate treatment and medications to limit disruptions at nighttime. Educate resident to limit caffeine intake. Increase daytime activity. Offer sleep medications as ordered at HS [bedtime]."</p> <p>The interventions listed on Resident #2's care plan were not implemented, as she was scheduled to bathe on the night shift. Her record did not include evidence of tracking her sleep</p>	F 242			

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F 242	<p>Continued From page 16</p> <p>hours, and her medication list did not include medications to induce sleep.</p> <p>b. During a phone interview on 10/19/16 beginning at 2:00 pm, Resident #2's POA stated Resident #2 did not know when her bathing times were. She stated she was not contacted for information related to Resident #2's preferences for bathing. She stated she was aware of Resident #2's insomnia, and thought her night hours were protected to include uninterrupted sleep.</p> <p>During an interview on 10/18/16 beginning at 2:50 pm, RN #1 stated Resident #2 was bathed that day early in the morning by the night shift. She stated she did not know Resident #2's preferences for bathing, and the Unit Manager assigned the bath schedules. RN 1 stated she was not aware that insomnia was included in Resident #2's diagnoses. When asked if that information was in Resident #2's care plan, RN #1 stated the care plans were very bulky, and she had not reviewed them in a very long time.</p> <p>During an interview on 10/20/16 at 2:05 pm, the Unit Manager of the Sol Oasis unit reviewed Resident #2's record and stated she did not implement the bathing schedule. She stated the bathing schedule for residents was initiated upon their admission. She stated Resident #2 was admitted approximately 3 years ago. The Unit Manager confirmed Resident #2's diagnoses included insomnia, and stated the care plan should have been reviewed and implemented appropriately.</p> <p>Resident #2's preferences for bathing and</p>	F 242			

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F 242	Continued From page 17 sleeping were not considered before developing her treatment schedules and care plans.	F 242			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure the needs of 2 of 15 sample residents (#4 & #5) were accommodated. The failure created the potential for emotional distress when Resident #4 was unable to access her personal items and lighting, and for discomfort and pressure ulcer development when Resident #5's bed was too short. Findings include:  1. Resident #4 was readmitted to the facility in March 2015, with multiple diagnoses including dementia, hemiplegia and hemiparesis related to a CVA, and major depressive disorder.  Resident #4's 10/1/16 quarterly MDS assessment documented she had moderately impaired cognition, required extensive 2 person assistance for bed mobility and transfers, and had functional limitation in ROM in 1 upper and 1 lower extremity.	F 246	246 Accommodation of Needs  1) Resident # 4 personal items were placed within her reach by UM or designee on or before 10/21/16. Room environment assessed by UM to ensure resident # 4 was able to reach her personal items and over bed light.  Resident # 5 had bed change on or before 10/21/16 by maintenance director. Resident satisfied with current bed  2) Staff were reeducated, on or before 11/30/16 by the Center Nurse Executive of designee on the purpose and intent of 42 CFR 483.15(e); and provided instruction on how to identify resident issues/concerns related to this requirement. Including the need to evaluate the resident environment on each visit to the room, paying attention to	12/14/16	

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F 246	<p>Continued From page 18</p> <p>Resident #4's care plan focus areas and their respective interventions included:</p> <ul style="list-style-type: none"> <li>* The importance for Resident #4 to have opportunities to engage in meaningful daily routines, revised 9/30/16 - Likes to read, listen to music, provide independent leisure materials as requested/available.</li> <li>* Exhibits symptoms of decline in cognitive function - "Allow the resident to make daily decisions about clothing, daily care, meal alternatives etc" and "Emphasize what this person can still do and encourage it daily." Both were revised 6/9/16.</li> <li>* At risk for falls - "Place glasses within reach and encourage use" and "When resident is in bed, place all necessary personal items within reach." Both were revised 3/17/15.</li> </ul> <p>On 10/17/16 at 1:25 pm, Resident #4 was observed awake on her left side in bed. The bed was in the low position. A radio, 2 stuffed animals, a strand of beads, a table lamp, and a stack of 4 books were on a bedside table 2 feet from the bed and 2 feet higher than the low bed. The lamp and books were on the far side of the table. In addition, the pull cord for the overbed light was hanging down by the foot end of the bed. Resident #4 said she could not reach the items on the bedside table or the overbed light pull cord. At that point, she activated her call light.</p> <p>On 10/17/16 at 1:28 pm, CNA #2 and CNA #3 responded to the call light and at 1:29 pm, CNA #4 also responded. None of the CNAs attempted to move the personal items or the overbed light</p>	F 246	<p>bed heights and the physical proximity of each residents preferred personal items and the residents ability to access them, as well as the functionality and appropriateness of equipment and furnishings in accordance with each residents individual needs.</p> <p>3) Beginning the week of 11/28/16 members of the center IDT will complete center rounds to ensure compliance with 42 CFR §483.15(e). Rounds will be completed 5 times weekly for 4 weeks; then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.</p> <p>4) Beginning in December 2016 results of the rounds will be presented in the center QAPI meeting for three months (or longer as necessary), with any identified negative trends addressed through system modification and staff education as appropriate.</p>		

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F 246	<p>Continued From page 19</p> <p>pull cord closer to Resident #4 before they left the room.</p> <p>On 10/18/16 at 8:47 am, CNA #4 was observed as she took Resident #4 to her room, removed her eyeglasses and placed them on the table by the bed, then transferred Resident #4 to bed and left the room. The CNA did not attempt to move the person items or the overbed light pull cord closer to Resident #4 before leaving the room.</p> <p>On 10/18/16 at 9:30 am, Resident #4's personal items and eyeglasses were on the bedside table and the overbed light pull cord were observed to still be inaccessible.</p> <p>On 10/18/16 at 9:45 am to 10:15 am, the DNS and RN #4 were observed as they provided care for Resident #4. Neither the DNS nor RN #4 attempted to move the personal items or the overbed light pull cord closer to the resident before they left the room.</p> <p>On 10/18/16 at 11:15 am, Resident #4 was observed in bed watching TV. Her eyeglasses and personal items were observed on the bedside table 2 feet away and 2 feet higher than the low bed and the overbed light pull cord still hung down by the foot of the bed. Similar observations were made at 1:35 pm, 2:20 pm and 3:30 pm on the same day.</p> <p>On 10/19/16 at 10:30 am, Resident #4 was observed in the low bed. Her eyeglasses and other personal items were still inaccessible on the bedside table and the overbed light pull cord was still inaccessible at the foot of the bed.</p>	F 246			

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F 246	<p>Continued From page 20</p> <p>On 10/19/16 at 10:35 am, the AIT was observed in Resident #4's room. When asked if she could reach her eye glasses, Resident #4 looked around then asked where her glasses were. The AIT said the glasses were on the bedside table. Resident #4 said she could not reach the glasses. The AIT handed the glasses to her. The AIT did not attempt to move Resident #4's other personal items on the bedside table or the overbed light pull cord closer to her before she left the room.</p> <p>On 10/19/16 at 10:38 am, the DNS and CNA #2 entered Resident #4's room. Resident #4 said "No" when asked if she could reach the pull cord for the overbed light. Neither the DNS or CNA #2 attempted to position the overbed light pull cord or the resident's personal items on the bedside table closer to her before they left the room.</p> <p>On 10/19/16 at 3:45 pm, and on 10/20/16 at 8:20 am and 10:10 am, Resident #4 was observed in bed. Her eye glasses and other personal items on the bedside table and the overhead light pull cord were still inaccessible.</p> <p>On 10/20/16 at 10:20 am, RN #4 was observed as she provided care for Resident #4. After the care, Resident #4 said "No" when asked if she could reach her eye glasses and other personal items on the bedside table or the overhead light pull cord. RN #4 did not attempt to move any of the items closer to Resident #4 before she left the room.</p> <p>On 10/20/16 at 4:30 pm, Resident #4 was observed awake in bed. She said she could not reach her personal items on the bedside table 2</p>	F 246			

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F 246	<p>Continued From page 21</p> <p>feet away and 2 feet higher than her low bed or the overhead light pull cord hanging at the foot end of the bed.</p> <p>2. Resident #5 admitted to the facility on 9/6/16. He required nursing and rehabilitation services following a right BKA due to a right heel pressure ulcer with development of wet gangrene.</p> <p>An MDS assessment, completed on 9/13/16, documented Resident #5 was cognitively intact and required extensive assistance of 2 staff for bed mobility and transfers. The MDS documented Resident #5's height as 75 inches (6 ft 3 in) and weight of 244 lbs.</p> <p>On 10/17/16 at 1:10 pm, Resident #5 was observed lying on a low air loss bed positioned on his back. The head of the bed was raised which placed him in a sitting position. Resident #5's left leg was extended out straight in front of him. The sole of his left foot was flat against the footboard of the bed.</p> <p>On 10/18/16 at 9:50 am, Resident #5 was observed lying on his back with the head of the bed raised so he could be a sitting position. The sole of his left foot was flat against the footboard of the bed.</p> <p>On 10/18/16 at 1:15 pm, Resident #5 was observed lying on his back. Upon interview, Resident #5 stated "This bed does not have a lot of room." His left foot was flat against the footboard.</p> <p>On 10/20/16 at 8:00 am, the UM stated she would see if the footboard could be extended. At</p>	F 246			

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F 246	Continued From page 22 10:00 am, Resident #5 was lying on his back with the head of bed raised to a sitting position. Resident #5's left foot was flat against the footboard. Resident #5 stated, "I think they are going to try to get me a bigger bed."	F 246			
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to provide medical social services for 3 of 6 residents (#1, #5, and #6) sampled for mental health related social services. As a result, a) Resident #1 was harmed when the facility failed to ensure psychosocial assessment and interventions were initiated after suicidal ideation requiring transport to a hospital ER, b) Resident #5 was harmed when the facility failed to clarify restrictions related to contact isolation, imposed stricter restrictions than clinically warranted, and failed to assess related psychosocial effects, and c) Resident #6 experienced the potential for harm when the facility failed to monitor behaviors related to psychotropic medication use. Findings include:  1. Resident #1 admitted to the facility 6/24/13, following hospitalization for a suicide attempt. Resident #1 had diagnoses of schizophrenia,	F 250	F250 Social Services  1) Residents #1, 5, and 6 had psychosocial assessments completed by LSW or RN on or before 11/30/16 regarding the lack of psychosocial support during their stay. None of the identified residents expressed any concerns or psychosocial distress.  2) Residents were reviewed by LSW on or before 11/30/16 for unmet psychosocial needs. Any needs identified were addressed when identified.  Facility LSW was educated by the Center Administrator on or before 12/14/16 regarding the requirements under 42 CFR §483.15(g)(1).  3) Beginning the week of 11/28/16	12/14/16	

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F 250	<p>Continued From page 23</p> <p>bipolar disorder, obsessive compulsive disorder, and depression.</p> <p>Resident #1's quarterly MDS assessment, dated 9/20/16, documented his cognition was intact and he had minimal depressive symptoms.</p> <p>Resident #1's care plan, dated 4/18/16, documented Resident #1 exhibited distressed mood symptoms of tearfulness and negative statements of "I just wanna die," along with a history of a suicide attempt requiring hospitalization in June 2013. The care plan documented Resident #1 may exhibit psychosocial distress about his own well-being. Interventions included allowing him time to verbalize anger and frustration, and staff to encourage him to utilize his identified coping skills. The care plan was documented as revised on 10/17/16. It was not clear how the care plan was revised as no suicide ideation, suicide intent, or suicide plan was documented on the care plan after the June 2013 information. There was no new interventions added.</p> <p>Resident #1's care plan, dated 4/18/16, documented he had expressed suicidal thoughts and was at risk for harming himself related to depression. Interventions included assessment of the resident's suicide risk, encouraging him to participate in diversional activities, placing and maintain suicide precautions, which included securing windows, removing items of danger from Resident's room i.e. sharp objects, plastic bags, ropes, ties, belts, etc. Resident #1 was to be provided meals on paper/plastic utensils, and closely supervise during all medication administration. The interventions also</p>	F 250	<p>members of the center IDT will complete center rounds to ensure compliance with 42 CFR 4483.15(b). Interviews will be completed for 5 residents weekly for 4 weeks; then 2 residents weekly for 8 weeks. Identified concerns will be corrected at the time referred to a Center Nurse Manager for resolution.</p> <p>4) Results of the rounds will be presented in the center QAPI meeting by the CNE or designee for three months (or longer as necessary) beginning in December, with any identified negative trends addressed through system modification and staff education as appropriate.</p>		

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F 250	<p>Continued From page 24</p> <p>documented Resident #1 focused on his fears of his bowel movements and should be redirected to a positive conversation.</p> <p>On 6/20/16, a Nurse Practioner Follow Up note, documented Resident #1 stated that he had regular bowel movements daily but after going, still felt the urge to defecate throughout the day. The NP documented this was discussed with staff, and was identified to be a chronic problem for quite some time. The NP documented Resident #1 was seen and evaluated by a gastroenterologist and had a colonoscopy with no pathology found.</p> <p>An MD visit Progress note, documented on 8/16/16, did not reference Resident #1's suicidal ideation or gastrointestinal concerns.</p> <p>On 8/31/16, a Psychiatry Follow Up note, documented Resident #1 had a history of periodic suicidal ideations but currently denied any such thoughts.</p> <p>On 9/12/16 at 5:53 pm, a Social Service note documented "Resident states that he is suffering and wants to have a bowel movement but cannot. Resident states that if he had a sharp object he would end the suffering and take his life. Sharp objects were removed from patient care area and he is a one to one. Resident did have ball point pens in his pocket which he had utilized in the past in an attempt to end his life. LSW did remove the pens and he immediately went to search for more. Resident is being sent out to the hospital for an evaluation. Resident states he is suffering and wants to no longer suffer. Resident is fixated on his bowel</p>	F 250			

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F 250	<p>Continued From page 25</p> <p>movement. Resident is at risk for harm at this time d/t his plan to harm himself."</p> <p>On 9/12/16 at 6:49 pm, a Nursing Home to Hospital Transfer Form, documented Resident #1 was transferred to the ER for suicidal thoughts. The form documented Resident #1 was stating "he will kill himself" and wanted to "stab himself with a pen or sharp object." The form did not provide communication of Resident #1 verbalizing he was suffering.</p> <p>On 9/12/16 at 9:30 pm, a nurses' note documented Resident #1 returned from the ER and a nursing admission assessment was completed.</p> <p>On 9/16/16 at 3:42 pm, a Social Service note documented Resident #1, "had a psychiatric consultation today. Resident with noted life changes and increase in signs and symptoms of depression including two statements of suicidal ideation." Resident #1's antidepressant dose was increased to assist with management of his symptoms."</p> <p>On 9/16/16, a Psychiatry Follow Up note documented Resident #1 had been voicing suicidal ideations and his antidepressant dose was increased.</p> <p>On 9/23/16 at 4:28 pm, a Social Service note from the SOPD, documented Resident #1 exhibited increased signs of agitation, such as pacing up and down the hallway stating "No one cares about me." Resident #1 declined that there was anything the SOPD could do to assist at this time. There was no documentation regarding the</p>	F 250			

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F 250	<p>Continued From page 26</p> <p>root cause of Resident #1's agitation, or that a referral was made to the facility's LSW.</p> <p>No further social service assessments or interventions were documented for Resident #1.</p> <p>On 9/27/16, a Psychiatry Follow Up Note documented, "Staff reports that the patient continues to express "life is not fun". He is having a lot of medical issues especially gastrointestinal problems."</p> <p>On 10/18/16, at 9:00 am, the SOPD stated Resident #1 resided on the Sol-Oasis unit, which was specific for residents who needed "extra support," which was defined as assistance with, "skills groups, socialization, coping challenges, we read the newspaper, and talk about their situations. The programming allows the residents to have positive interaction with the staff."</p> <p>On 10/18/16 at 10:00 am, Resident #1 stated he did not usually participate in activities or Sol-Oasis groups. Resident #1 responded "no" when asked if the LSW, Sol-Oasis program staff, or others provided additional individual support. When asked what he did during his day, he stated, "Just go to appointments and stuff."</p> <p>On 10/19/16 at 8:00 am, Resident #1 was observed during breakfast. A stainless steel knife, fork, and spoon was provided to him. At 5:00 pm, Resident #1 received stainless steel silverware with his dinner meal.</p> <p>Resident #1 was harmed when the facility failed to provide ongoing social services when he was admitted to the facility following a suicide attempt.</p>	F 250			

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F 250	<p>Continued From page 27</p> <p>Resident #1's care plan did not include information on how staff should recognize or act given his known history of suicide attempts. On 9/12/16, Resident #1 threatened suicide using the same method for which he had been previously hospitalized. Resident #1 was sent to the hospital for emergent evaluation of his suicidal ideation and plan. After Resident #1 returned to the facility, new individualized social service interventions were not developed or implemented to address the issues leading up to the suicide attempt, or to recognize and intervene with further signs of suicidal ideation. Resident #1 was noted with continued alterations in his mood state on 9/23/16 and 9/27/16.</p> <p>2. Resident #5 was admitted to the the facility on 9/6/16, for post surgical rehabilitation following a below the knee amputation of the right lower extremity. Diagnoses included a pressure ulcer to sacrum requiring a wound vac, depression, and bipolar disorder.</p> <p>Per an Initial Psychiatric Evaluation Note, dated 9/16/16, Resident #5 had a remote history of 3 attempted suicide attempts. Resident #5's H&amp;P documented he had been living independently in the community until March 2016, when he was in a motor vehicle accident and sustained a number of significant injuries, including multiple fractures. The H&amp;P documented Resident #5's recovery had been complicated by pressure ulcers on his sacrum and right heel, which caused him a great deal of pain. Resident #5's right leg was amputated below the knee on 8/29/16.</p> <p>Resident #5's admission MDS assessment, dated 9/13/16, documented the resident's</p>	F 250			

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F 250	<p>Continued From page 28</p> <p>cognition was intact and he had no depressive symptoms. On 9/9/16 at 9:21 am, nurses' notes documented lab results for stool sample positive for C-diff and Resident #5 was on contact precautions. According to the most recent CDC guidelines, others needed to use PPE only if they were going to come in contact with stool or provide personal cares. Strict handwashing would have been enforced. Social outings or interaction with others required no special equipment or restrictions.</p> <p>Resident #5's care plan, dated 9/16/16 and revised on 10/17/16, documented he was at risk of a distressed or fluctuating mood. The interventions included engagement in one to one visits for healthy development of coping skills. A second focus area (date) documented Resident #5 had poor coping skills, and "Sol Oasis program staff" would work with him on healthy ways to cope. A third focus area dated (date) documented Resident #5 had psychosocial distress related to himself and his social relationships. The interventions documented staff would mediate interactions with family, visitors, other residents, and staff.</p> <p>Resident #5's care plan, dated 9/16/16, also documented he was at risk of substance abuse of opioids related to a history of addiction with poor coping skills and adjustment issues. The interventions included reminding the resident of his "need for a plan for recovery and sobriety" as a means of improving his judgment; and working with "Sol-Oasis program staff" on coping, communication, and socialization skills.</p> <p>On 9/9/16 at 4:30 pm, a Social Service note</p>	F 250			

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F 250	<p>Continued From page 29</p> <p>documented the AIT and the LSW visited Resident #5 to educate him after the NP reduced his pain medication. The note documented Resident #5 became upset because "my leg was just amputated" and told the AIT and LSW to get out of his room. The LSW's response to this was "attempted to redirect and did educate resident they would be exiting at this time." It was not clear which coping skills the AIT and LSW had encouraged Resident #5 to develop in response to the reduction in his pain medications while his surgical site from his recent amputation was still in the healing process.</p> <p>A care plan intervention, dated 9/9/16, documented that meaningful activity for Resident #5 was to go outside for fresh air in good weather and that he should be provided access to outdoor areas.</p> <p>On 9/16/16 at 9:41 am, a Social Service note documented Resident #5 had increased agitation and was yelling at staff. The note documented the LSW assisted with adjustment and coping skills, and Resident #5 agreed to utilizing counseling. At 3:41 pm, the LSW documented Resident #5 had completed a psychiatric consult and was adjusting to the facility.</p> <p>On 9/17/16 at 12:26 pm, a Social Services note documented an offer of individual counseling services in the facility, and Resident #1 signed a consent form. Two days later, on 9/19/16, Social Services notes documented the referral was faxed to the counseling agency. Nine days later, on 9/28/16, a Social Services note documented Resident #5 could not be seen by the counseling</p>	F 250			

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F 250	<p>Continued From page 30</p> <p>agency due to insurance coverage issues, and a different provider would be arranged. There was no further documentation in Resident #5's record regarding the status of counseling services, or documentation that counseling services were provided.</p> <p>On 9/28/16 at 3:00 pm, a nurses' note documented Resident #5 was overheard to have an argument with his spouse during which he stated he no longer wanted that individual to be his POA. The note documented the resident's spouse came to the nurse afterwards and told the nurse she was leaving the resident, and identified a number of potential psychosocial issues for Resident #5. There was no documentation of mediation between the Resident #5 and his spouse, as documented in Resident #5's care plan. There was no documentation of a social services referral. There was no documentation in Resident #5's record that social services met with him regarding this incident, or his statement of wanting to change POA's.</p> <p>On 10/5/16 at 10:59 am, a Social Services progress note documented the LSW and AIT met with Resident #5 following a report that Resident #5 threatened to grab the CNA and get the CNA fired. The Social Services note documented, "educated [Resident #5] that staff also have rights and they do include being treated in a respectful manner ...educated [Resident #5] staff can call the police if they feel threatened." The note did not document what prompted this conversation, and no investigation into the incident was documented. It was not clear how the facility determined the incident was a result of</p>	F 250			

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F 250	<p>Continued From page 31</p> <p>unlawful behavior on Resident #5's part, and not an expression of an unmet physical, mental, or psychosocial need. There was no documentation that LSW provided support to Resident #5 or assisted him to develop coping skills.</p> <p>On 10/5/16, a Nurse Practitioner Follow-Up Note documented "According to staff, resident has had some behavioral issues, becoming quite agitated and verbally abusive to staff. The resident tells me when asked about this that he is very frustrated being in isolation due to C-Diff and after discussion, he does feel the symptoms will improve once he is able to get up and out of his room." The NP assessment documented that Resident #5 was becoming more and more frustrated with the isolation in his room which could be contributing, not only to his agitation, but his perception of pain.</p> <p>On 10/10/16 at 7:31 pm, a Social Services note documented Resident #5's desire to be discharged to the community against medical advice due to, "[Resident] is wanting more medications without putting in the work to improve his mood without psychosocial interventions..." It was not clear what "work" Resident #5 was unwilling to do to improve his mood state, or to which psychosocial interventions he was objecting. There was no documentation that the psychosocial interventions were reviewed and revised in light of Resident #5's unwillingness to utilize the ones currently in place. There was no documentation of follow-up on the counseling referral from 9/17/16.</p> <p>On 10/14/16 at 12:48 pm, a Social Service note</p>	F 250			

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F 250	<p>Continued From page 32</p> <p>documented Resident #5 was notified of a room transfer. On that date, he moved to a room on the facility's 200 hall, called the "Sol-Oasis" unit by the facility. There was no documentation as to the reason Resident #5 required a room transfer, how the change was beneficial to him, or whether he agreed to the transfer.</p> <p>On 10/14/16 at 2:06 pm, a Social Services note documented the SOPD met with Resident #5 regarding the opportunity to transition to the Sol-Oasis program to work on "healthy coping during frustrating situations." The note documented Resident #5 would have the opportunity to participate in group programming, as well as, receive visits from program staff. It was not clear if Resident #5 was informed that he had the opportunity to participate in the Sol-Oasis programming without moving rooms.</p> <p>On 10/15/16 at 1:23 pm, a Social Services note documented a SOPD follow up visit with Resident #5 after his transition to the Sol-Oasis program. The note documented Resident #5 and the SOPD discussed football.</p> <p>On 10/17/16 at 10:50 am, the door to Resident #5's room was closed with a sign directing visitors to check with a nurse prior to entering the room. RN #3 stated Resident #5 was on contact precautions and instructed the surveyor that prior to entering the room, a disposable clothing cover, gloves, and a mask must be put on. The DON stated that everyone entering Resident #5's room had to adhere to the use of the PPE. At 1:30 pm, CNA #1 stated a gown, gloves, and mask was used because Resident #5 was on contact precautions.</p>	F 250			

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F 250	<p>Continued From page 33</p> <p>On 10/17/16 at 1:10 pm, Resident #1 stated he was moved to the Sol- Oasis unit for group therapy to "deal with my bipolar disorder." Resident #5 stated he had not had any therapy.</p> <p>On 10/18/16 at 1:15 pm, the door to Resident #5's room was closed. Resident #5 stated he was not sure why it was closed. Resident #5 stated before his recent room change, the door was always open. Resident #5 stated he understood he had been moved to the new room so he could participate in Sol Oasis programming, but he liked his previous room better because of the view and air flow. Resident #5 stated that due to his isolation precautions, he was only able to leave the room for appointments outside of the facility.</p> <p>On 10/19/16 at 3:50 pm, the LSW stated because Resident #5 was on isolation precautions, she had to wear gloves, a mask, and shoe coverings whenever she went into his room. The LSW stated she was aware of Resident #5's preference to be outside, but those outings would be arranged by the Activities staff. The LSW stated she was not sure how often they were offered, or how receptive Resident #5 was to going outside. The LSW stated she had offered to take Resident #5 outside, but he always declined. The LSW stated she had not documented either the offers or the refusals because, "That's not what he expects from social work visits. I'm there for other things, not to take him outside."</p> <p>During the same interview, the LSW stated she had provided a referral for Resident #5 to have</p>	F 250			

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F 250	<p>Continued From page 34</p> <p>counseling with the provider that typically came into the facility to provide services. The LSW stated she later found out the provider was out of network for Resident #5's insurance company. The LSW stated Resident #5 identified his preferred provider was in a neighboring community, where he had lived prior to his accident. The LSW stated the facility was unable to provide transportation to the neighboring community, so she was waiting for Resident #5 to identify a provider in the local community. The LSW stated she had not given Resident #5 referrals for local providers, but was waiting for the name of a provider from him. The LSW stated she had not documented the work she had done on this matter since finding out the in-house provider could not see Resident #5.</p> <p>During the interview, the LSW stated she was not sure what prompted the increase in Resident #5's "agitation and yelling" on 9/16/16. The LSW stated, "He was probably having a fight with his wife." The LSW stated she had not documented an assessment of Resident #5's psychosocial status at baseline, so was unable to state how she had determined Resident #5's "yelling and agitation" levels had increased.</p> <p>3. Resident #6 was re-admitted to the facility on 10/5/12 with multiple diagnoses, including paranoid schizophrenia.</p> <p>a. Resident #6's October 2016 Physician Orders Review, documented he received Risperdal 3 mg at bedtime for paranoid Schizophrenia, beginning 8/12/16. Resident #6 had been on Risperdal previously, since admission, at varying doses.</p>	F 250			

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F 250	<p>Continued From page 35</p> <p>An 8/20/16 Quarterly MDS assessment, documented Resident #6 exhibited no behaviors or cognitive or decision making impairments, and presented with no signs of depression. The MDS documented he had delusions, however, no hallucinations or psychosis-related behaviors. Resident #6's previous MDS assessments from December 2015 through May 2016 documented no delusions, hallucinations or psychosis-related behaviors.</p> <p>Resident #6's Impaired Cognitive Function Care Plan, revised 4/3/16, documented he was at risk for a cognitive decline related to hallucinations and delusions. The care plan did not include his use of the psychotropic medication or resident-specific behaviors staff were to monitor for.</p> <p>Resident #6's Delirium Care Plan, dated 9/23/15, documented he was at risk for symptoms of delirium. Interventions included staff was to attempt to refocus Resident #6 to something positive when he was delusional.</p> <p>Resident #6's Psychosocial Well-being Care Plan, revised 4/3/16, did not include his use of the psychotropic medication or resident-specific behaviors staff were to monitor for. Resident #6's interventions were updated 8/5/16, to include him attending the Sol Oasis Program Groups and staff was instructed to encourage him to participate in social based groups where he could receive positive feedback for his efforts.</p> <p>A 3/18/16, Psychiatrist note documented Resident #6 had no evidence of psychotic symptoms. The note documented he was stable</p>	F 250			

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F 250	<p>Continued From page 36 on a low dose of Risperdal.</p> <p>A 6/10/16, Psychiatrist note documented Resident #6 had no evidence of psychotic symptoms. The note documented a GDR was recommended and the facility was to continue psychosocial and environmental interventions.</p> <p>A 7/15/16, a Psychiatrist note documented Resident #6 had some delusional thinking and denied hallucinations. The note documented the nursing staff reported to the physician that Resident #6 had increased irritability and poor decision making and had experienced delusions about surgical incisions in his buttock area that prevented him from taking showers. The documentation did not include how the delusional thinking affected Resident #6 negatively or non-pharmalogical interventions attempted. In addition, the note documented Resident #6's Risperdal was increased. There were no corresponding nursing notes documenting the delusions or increased irritability and poor decision making in Resident #6's records.</p> <p>A 7/26/16, Social Services' note documented Resident #6 told staff he had received a check and wanted to get the money. Resident #6's record did not document how the check was a delusion. In addition, it did not document how the check affected Resident #6 negatively.</p> <p>A 7/27/16, Psychiatrist note documented Resident #6 had some delusional thinking. In addition, the note documented his Risperdal was increased.</p> <p>A 8/12/16, Psychiatrist note documented</p>	F 250			

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F 250	<p>Continued From page 37</p> <p>Resident #6 experienced delusions of persecution and somatic in nature, however he denied hallucinations. In addition, the note documented his Risperdal was increased.</p> <p>A 8/19/16, Psychiatrist note documented Resident #6 had some delusional thinking but did not describe the delusions or their effect on Resident #6.</p> <p>Resident #6's Social Services' Psychotherapeutic Meeting Notes, dated 6/10/16, 7/15/16, 7/27/16, and 8/12/16, did not document the type and frequency of delusions or hallucinations he experienced. In addition, the notes did not document how they affected him negatively.</p> <p>A 9/29/16, Resident Assessment Note documented Resident #6 had no changes in behavior symptoms and he experienced hallucinations, and was self-isolating. The note did not describe what the hallucinations were.</p> <p>Resident #6's 6/1/16 - 10/18/16 MAR/TAR Behavior Monitoring records, documented staff were to monitor for behaviors to include self-isolation, hallucinations, and rejection of cares.</p> <p>The 6/1/16 - 10/18/16 MAR/TAR Behavior Monitoring records, documented Resident #6 did not experience episodes of hallucinations, self-isolation, or rejection of cares.</p> <p>The 6/1/16 - 10/18/16 MAR/TAR Behavior Monitoring records did not monitor for delusions.</p> <p>On 10/20/16 at 9:50 am, the LSW stated</p>	F 250			

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F 250	<p>Continued From page 38</p> <p>Resident #6 experienced a hallucination of getting a check and he wanted his money. This happened back in July of 2016. She stated he said he had seen the check and did not know what happened to it. She stated he continued to perseverate on the check. Resident #6's guardian was asked about the check and stated he did not receive one. The LSW stated his guardian asked for him to be re-evaluated by the psychiatrist because he was distracting her with continually asking about seeing his financial information and wanting be become his own guardian. The LSW stated she could not tell the difference between his delusions or hallucinations. She stated the facility monitored for all type of delusions and hallucinations to include dysphoric [unhappy] in nature or happy in nature. She stated it was up to the psychiatrist to determine what type of delusions required medications. She stated Resident #6's psychiatrist wanted to see Resident #6's psychosocial health stabilize and his delusions better controlled. The LSW stated she could not find documentation in Resident #6's record that he was being monitored for delusions.</p> <p>Resident #6 was not effectively monitored for hallucinations and delusions to measure the efficacy and continued use of the antipsychotic medication, Risperdal. In addition, Resident #6's clinical record did not include instructions for staff to monitor and document his delusions or lack of them.</p> <p>b. An 8/20/16 Quarterly MDS assessment, documented Resident #6 exhibited no behaviors or cognitive or decision making impairments, and presented with no signs of depression. The MDS</p>	F 250			

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F 250	<p>Continued From page 39</p> <p>documented he had delusions, however no hallucinations or psychosis-related behaviors. Resident #6's previous MDS assessments from December 2015 through May 2016 documented no delusions, hallucinations or psychosis-related behaviors.</p> <p>Resident #6's Psychosocial Well-being Care Plan, dated 4/3/16, did not include his use of the psychotropic medication or resident-specific behaviors staff were to monitor for. Resident #6's interventions were updated 8/5/16, to include him attending the Sol Oasis Program Groups and staff was instructed to encourage him to participate in social based groups where he could receive positive feedback for his efforts.</p> <p>A 7/11/16, Social Services' note documented Resident #6 was upset that he had a guardian and wanted the guardianship revoked. The social services notes, from 5/3/16 to 10/18/16, did not include documentation of guidance provided to Resident #6 related to becoming his own guardian.</p> <p>A 7/18/16, Social Services' note documented Resident #6's guardian contacted the LSW and wanted a letter from a psychiatrist which stated he was incompetent to make his own decisions. In addition, the note documented Resident #6 had a psychiatrist appointment in two weeks and the psychiatrist would assess the resident.</p> <p>A 7/27/16, Psychiatrist note documented Resident #6 had some delusional thinking. The note documented he experienced anxiety because he was not allowed to live independently.</p>	F 250			

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F 250	<p>Continued From page 40</p> <p>A 7/28/16, Social Services' note documented Resident #6 was provided with filters for his hand rolled cigarettes. The note documented he told the Social Services Assistant that he did not want to use them, however, the Social Services Assistant placed one of the filters onto one of his cigarettes. In addition, the note documented Resident #6 took off the filter and stated again he did not want to use them.</p> <p>An 8/12/16, Psychiatrist note documented Resident #6 wanted to manage his own affairs and become his own guardian. The note documented Resident #6 had a legal guardian. The note further documented Resident #6 knew he had a short term memory problem that did affect his day-to-day functioning, however he felt that he could still make decisions for himself.</p> <p>A 8/12/16, Social Services' note documented Resident #6 was angry with his psychiatric consultation and had utilized coping skills and socialization to overcome his anger. The note did not document what services Social Services had offered as support or guidance.</p> <p>A 9/15/16, Social Services' Note documented Resident #6 declined to participate in any open groups available throughout the day.</p> <p>A 9/17/16, Social Services' Note documented Resident #6 declined to participate in a social group, because he needed to roll his cigarettes.</p> <p>A 9/20/16, Social Services' Note documented Resident #6 declined to participate in an open group and the Social Services Assistant</p>	F 250			

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F 250	<p>Continued From page 41</p> <p>educated him that attending groups may help him to achieve his goal of returning to another hall in the facility.</p> <p>On 10/18/16 at 2:25 pm, Resident #6 stated he did not know why he was moved to the current room he was in. He stated he did not mind rolling his cigarettes but it was his prescription to roll them in a group atmosphere. He stated he had a brain injury years ago and does not enjoy things like he used to. He stated he did not feel like people listened to what he wanted.</p> <p>On 10/20/16 at 9:50 am, the LSW stated his psychiatrist wanted to see Resident #6's psychosocial health stabilize and his delusions better controlled before determining if Resident #6 was competent to manage his own affairs. The LSW stated it was not a goal for Resident #6 to move back to the other hall. She stated he could move anytime if he wanted to. She did not know why it was listed as a goal for Resident #6 to move in the Social Services' note, dated 9/20/16, see above. In addition she said to ask the Social Services Assistant who wrote the note.</p> <p>On 10/20/16 at 4:20 pm, the Social Services Assistant stated it was a goal for everyone on the Sol-Oasis hall to transition out of unit to another hall in the facility. She stated they could stay in the Sol Oasis hall if they wanted to. She did not realize this goal was not on his care plan and stated the LSW, herself, and the Sol-Oasis Manager determined goals for residents.</p> <p>Social services did not assist Resident #6 with his psychosocial needs or take his preferences into account.</p>	F 250			

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F 250	<p>Continued From page 42</p> <p>c. A 8/20/16 Quarterly MDS assessment documented Resident #6 had delusions.</p> <p>Resident #6's clinical records contained two Certificates of Service for Guardianships, notarized 2/17/12 and 6/2/15. These documents appointed a guardian for Resident #6.</p> <p>A 7/11/16, Social Services' note documented Resident #6 was upset and had called an attorney's office to request the guardianship be revoked. The note documented the attorney's office reviewed his case and found that Resident #6 did not have a Guardian Ad Litem assigned to him. In addition, the note documented Resident #6 needed a psychiatric evaluation to determine whether he was able to manage his own care. The LSW documented that would happen on the 7/15/16.</p> <p>A 7/18/16, Social Services' note documented Resident #6's guardian needed a letter from his psychiatrist stating Resident #6 was incompetent to make his own decisions. The note documented the psychiatrist was unwilling to do this at that time and he would be reviewing Resident #6 later in the month.</p> <p>On 10/20/16 at 2:00 pm, the LSW stated she had nothing to do with helping residents get guardian ad litem's. It was the court's decision and it was up to the court. She stated Resident #6's psychiatrist still had not given his determination of Resident #6's cognitive status. She stated Resident #6 had a guardian currently. The LSW agreed that people with guardians should have a guardian ad litem as a resident advocate. She</p>	F 250			

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F 250	Continued From page 43 stated that since writing the note on 7/18/16, she had not completed further follow up related to Resident #6 securing a guardian ad litem or his desire to become his own guardian.	F 250			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the environment was safe, clean, and homelike for 1 of 15 sampled residents (#6), all residents who dined in the 2 of 2 east hall dining areas (Dining Areas A and B), and residents who went through the hallway to the West Wing dining area. The failure created the potential for residents to experience a negative effect on their psychosocial well being. Findings include:  1. During an observation of breakfast in the Sol Oasis dining room [Dining Area A] on 10/20/16 at 7:48 am, a refrigerator/freezer was noted in the dining room. The door handles each had a wire cord wrapped through them and were secured with a padlock. A CNA stated it was used to store residents' food. When questioned why it was padlocked, she responded "To keep residents out." She stated if it was not locked, the contents would be taken by others, and the residents's private foods and drinks would not be available.	F 252	252 Safe, Clean, Comfortable Environment  1) The resident refrigerator remains locked, in accordance with the residents' preference, to ensure the security of the residents' personal food items.  A bid was obtained by the facility Director of Maintenance and approved by the facility administrator on or before 11/30/16 for the repair of the windows with condensation. The necessary supplies have been ordered by the vendor. The repairs were completed on or before 12/6/16 Resident # 6 had wedge cushion changed on or before 10/21/16 by UM.  Signs were removed from the ice chests.  2) Resident areas were audited to	12/14/16	

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F 252	<p>Continued From page 44</p> <p>The CNA was able to secure a key and unlock the padlock. The freezer included a gallon-sized plastic bag which was labeled "Flax Seed, 6/25/16." The CNA stated the resident whose name was on the label was no longer at the facility. She stated the dietary department was responsible for checking for outdated and expired items.</p> <p>The facility provided a refrigerator/freezer for the residents' use, however access was limited as evidenced by the wire cord and padlock.</p> <p>2. A tour of the facility was conducted on 10/21/16 beginning at 8:40 am. The tour was led by the facility Environmental Services Director, Maintenance Director, and the District Manager for the company that provided contracted services of dietary, housekeeping, and laundry.</p> <p>During the tour of the west wing, the hallway between the outside wall and the dining room had dual pane windows which overlooked the grounds. Multiple windows were noted to have condensation droplets between the panes. Additionally, the framework between the upper windows and the lower windows had hard water stains which appeared as long thin lines of scale-type white material. The Maintenance Director looked at the condensation and the stains on the windows and frames, and stated it was impossible to get rid of the condensation without removing the windows.</p> <p>The facility did not ensure a clean and homelike environment was provided to all residents.</p> <p>3. On 10/17/16 at 10:56 am, Resident #6 was</p>	F 252	<p>ensure a safe, clean, comfortable, homelike environment by center staff, on or before 11/30/16. Any areas identified as a concern were referred to the appropriate department for remediation.</p> <p>3) Center staff were educated on or before 12/12/16 by the Center Nurse Executive or designee regarding the requirements found at 42 CFR 483.15(h) (1), and how to identify and address variances to this requirement; including but not limited to use of the facility Maintenance Log.</p> <p>4) Center Maintenance Director and/or Housekeeping Director or designees will complete rounds of the facility twice weekly for 4 weeks and then weekly for one month, and then monthly for homelike environment issues. Findings will be corrected when identified and audit results will be presented at the monthly performance improvement committee by the Center Maintenance Director beginning in December 2016 for a minimum of 3 months or until substantial compliance is achieved.</p>		

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F 252	Continued From page 45 observed sitting in his wheelchair and had a wedge adductor between his knees. The wedge was blue with multiple areas of a dark ash color on the top and the front, which covered approximately 60% of the surface area. The wedge was held in place with a strap. The strap was white with stains of an ash color covering approximately 50% of the surface. The wedge was observed to be in the same repair on 10/18/16 at 8:28 am, 10/18/16 at 2:25 pm, 10/19/16 at 10:12 am, and 10/20/16 at 7:27 am.  On 10/20/16 at 11:16 am, the DNS and RN #3 stated they had not examined the wedge recently for cleanliness but would do so now.  4. Two refrigerations were observed in Dining Area B, on the East unit of the facility, on 10/19/16 at 9:00 am. Both refrigerators had "padlocks" on the doors. One of the 2 refrigerators had a sign on the front that read, "please keep locked at all times for resident safety". There was no key to these refrigerators in sight. The one ice chest in Dining Area B had ice in it but had a sign on the top that read "Need ice? Please ask for assistance."	F 252			
F 278 SS=E	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.	F 278		12/14/16	

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F 278	<p>Continued From page 46</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and POA interview, and record review, it was determined the facility failed to ensure 4 of 13 (#2, #6, #8, and #10) sampled residents' needs and conditions were accurately assessed to provide ongoing care to maintain and/or improve their medical status. These assessment failures placed residents at risk for not receiving care to prevent physical declines and improve or maintain their health and wellbeing. Findings include:</p> <p>1. Resident #10 was re-admitted to the facility on 4/19/16. Resident #10's diagnoses included muscle atrophy and contractures of the left foot and right hand. It was Resident #10's third</p>	F 278	<p>278 Accuracy of Assessments</p> <p>1) An expanded nursing assessment was completed for residents #2,#6 and #8 to validate current medical status. An MDS was completed reflecting the assessment by Clinical Reimbursement Coordinator (CRC) or designee on or before 11/30/16. A note was placed in Resident #10's permanent record, on or before 12/12/16 by a Registered Nurse, explaining why the diagnoses noted were not coded under section G 0400 of the MDS because the condition did not limit her functional activities until noted in section G in July.</p>		

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F 278	<p>Continued From page 47 admission between 3/11/16 and 4/19/16.</p> <p>Resident #10's Care Area Assessment Worksheet (CAA), dated 3/30/16, completed during a prior admission, indicated Resident #10 needed a restorative nursing program. Under "limitations" there were no limitations assessed. Resident #10's MDS Quarterly Assessment, dated 7/27/16, identified an active diagnosis of "contracture right hand."</p> <p>Resident #10's MDS assessment findings were not consistent with her prior diagnoses and assessments, nor was there documentation to explain the inconsistencies.</p> <p>2. Resident #8 was admitted to the facility on 4/10/15, with no diagnosis of wandering behaviors.</p> <p>Resident #8 was observed, on 10/19/16 at 9:50 am, with a "wander guard" on her left ankle.</p> <p>Resident #8's MDS Assessment, dated 9/29/16, documented she did not engage in wandering activity.</p> <p>3. Resident #6 was re-admitted to the facility on 10/5/12, with multiple diagnoses, including paranoid schizophrenia, GERD, muscle wasting and atrophy, abnormal posture, anemia, neurogenic bladder, and hypothyroidism.</p> <p>The 8/20/16 Quarterly MDS assessment documented Resident #6 had no range of motion impairments of his lower and upper extremities on either side.</p>	F 278	<p>2) MDS□s completed over the past 14 days were reviewed for accuracy by and Center□s Clinical Reimbursement Coordinator. Any inaccurate entries were corrected at the time identified, and the IDT member completing the inaccurate area was educated.</p> <p>3) In the future MDS accuracy will be reviewed prior to submission by the center□s Clinical Reimbursement Coordinator until confidence in accuracy is achieved.</p> <p>Licensed nurses have been educated on or before 11/30/16 by CNE or designee regarding the importance of accuracy in the completion of individual assessments, to ensure that the proper care is provided and the data carried over to the MDS electronically is accurate.</p> <p>4) The center□s Clinical Reimbursement Coordinator will review, for accuracy, the MDS sections completed by IDT members by reviewing at random, 5 MDS□s per week for the first 4 weeks and then 5 per month for two months. Any inaccuracies will be corrected prior to transmission with education provided at the time of the finding. The results of these audits will be presented in the monthly QAPI meeting by the CNE or designee beginning in December 2016 for three months, or until substantial compliance is achieved.</p>		

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F 278	<p>Continued From page 48</p> <p>Resident #6's previous MDS assessments, from December 2015 through May 2016, documented he had range of motion impairments in his lower extremities on both sides.</p> <p>On 10/17/16 at 11:00 am, Resident #6 was sitting in his wheelchair with his foot turned slightly outward and a wedge between his knees. Resident #6 stated he had to have the wedge between his knees because without the wedge his legs would cross and put pressure on his legs. He stated his legs and foot had been like that for a while.</p> <p>On 10/20/16 at 11:16 am, the DNS and RN #3 stated Resident #6 had a foot deformity and he did have ROM issues with his lower extremities, which required use of the wedge.</p> <p>4. Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease. Resident #2's record documented she was bed bound, and had not been out of bed for greater than 2 years. MDS assessments were reviewed, and conflicting information between the annual assessment and most recent Quarterly assessment were found. Examples are as follows:</p> <p>An Annual MDS assessment was performed on 2/10/16, and the Quarterly assessment was performed on 8/8/16.</p> <p>a. Item A 1200, "Marital Status"</p> <p>* Annual and Quarterly MDS assessments</p>	F 278			

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F 278	<p>Continued From page 49 documented widowed.</p> <p>During an interview on 10/19/16 at 2:00 pm, Resident #2's POA stated Resident #2 was never married.</p> <p>b. Item A 1300, "Lifetime Occupation"</p> <p>* Annual MDS documented retired.</p> <p>* Quarterly MDS documented teacher.</p> <p>c. Item A 1900, "Admission Date"</p> <p>* Annual MDS documented 2/14/13.</p> <p>* Quarterly MDS documented 10/8/13.</p> <p>d. Item B 1200, "corrective lenses"</p> <p>* Annual MDS documented "yes"</p> <p>* Quarterly MDS documented "no"</p> <p>e. Item E 0800, "Rejection of care"</p> <p>* Annual and Quarterly MDS assessments documented "0" Behavior not exhibited".</p> <p>Resident #2's MAR and TAR, as well as, her progress notes documented repeated episodes of rejection of care, ADL assistance, and medications during the periods of the MDS assessments.</p> <p>e. Item G 0110, "ADL Assistance"</p> <p>* Annual MDS documented Resident #2 was</p>	F 278			

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F 278	<p>Continued From page 50</p> <p>totally dependent with the following activities:</p> <p>-bed mobility, dressing, and personal hygiene.</p> <p>* Quarterly MDS documented Resident #2 required extensive assistance with the following activities:</p> <p>-bed mobility, dressing, and personal hygiene.</p> <p>f. Item G 0400, "Functional Limitation in Range of Motion"</p> <p>* Annual MDS documented upper and lower impairment on both sides.</p> <p>* Quarterly MDS documented no impairment of upper or lower extremities of either side.</p> <p>Resident #2's physician progress notes, OT notes, and nursing notes during the time periods of each MDS assessments documented contractures in her right and left hands, as well as, her left arm.</p> <p>g. Item I 5600, "Active Diagnosis in the last 7 days"</p> <p>* Annual and Quarterly MDS assessments each documented Psychotic Disorder.</p> <p>Resident #2's record documented she was on Abilify during the annual MDS assessment, which was documented as ordered for depression. Additionally, her nursing and physician progress notes and behavior monitoring sheets did not document psychotic behavior.</p>	F 278			

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F 278	<p>Continued From page 51</p> <p>h. Item I 8000, "Additional active diagnoses"</p> <p>* Annual and Quarterly MDS assessments each documented Proteus causing disease elsewhere, encephalopathy, and long term use of anticoagulants.</p> <p>The above diagnoses were not included in Resident #2's hospital H&amp;P dated 10/4/13, or in her current facility physician progress notes.</p> <p>i. Item O 0500, "RNA" Program, the number of days the restorative program was performed for at least 15 minutes a day in the last 7 calendar days.</p> <p>* Annual MDS assessment documented 4, for splint or brace assistance, which indicated Resident #2 received 4 days of RNP/RNA assistance.</p> <p>* Quarterly MDS assessment did not include documentation that Resident #2 was included in an RNP program.</p> <p>The RNP program for February 2016, documented a single 20 minute session on 2/3/16, for the 7 calendar days prior to the Annual MDS assessment dated 2/10/16.</p> <p>During an interview on 10/18/16 beginning at 10:00 am, the Unit Manager of the Sol Oasis Unit reviewed Resident #2's MDS Annual and Quarterly assessments. She stated she did not perform the MDS assessments, and was surprised to see the conflicting information in the assessments and medical record. The Unit Manager stated she did not know why the MDS</p>	F 278			

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F 278	Continued From page 52 assessment did not document contractures, as they had been present for greater than 1 year. She stated the active diagnoses information was "probably" inaccurate, as she was not on anticoagulants, and had not had psychotic behavior "for a long time."	F 278			
F 279 SS=D	Resident #2's MDS Annual and Quarterly assessments were not accurate. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined	F 279	F279 Comprehensive Care Plans	12/14/16	

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F 279	<p>Continued From page 53</p> <p>the facility failed to ensure individualized care plans were developed, based on comprehensive assessments that identified limited ROM, for 2 of 10 residents (#2 &amp; #4) reviewed for ROM and contractures. The failure created the potential for more than minimal harm if the residents' ROM deteriorated further as a result of not receiving treatment and services due to lack of direction in their care plans. Findings include:</p> <p>1. Resident #4 was initially admitted to facility in 2007 and re-admitted in 3/11/15, with multiple diagnoses including, dementia, hemiplegia and hemiparesis related to a CVA, muscle weakness, muscular wasting and disuse atrophy and difficulty walking.</p> <p>Resident #4's 10/1/16 quarterly MDS assessment documented moderate cognitive impairment, functional limitation in ROM in one upper and one lower extremity, OT services between 6/23/16 and 7/14/16, PT services between 1/29/16 and 2/8/16, and that a restorative nursing program was not provided.</p> <p>Resident #4 was observed with her right leg angled forward and both knees bent at a 90 degree angle on:</p> <ul style="list-style-type: none"> <li>* 10/17/16 at 1:25 pm</li> <li>* 10/18/16 at 8:50 am during a w/c to bed transfer by CNA #7</li> <li>* 10/18/16 9:00 am, 9:30 am, and 9:55 am to 10:15 am, during direct care and repositioning in bed by the DNS, and RN #4 at 11:15 am, 1:35 pm, 2:20 pm and 3:30 pm</li> <li>* 10/19/16 at 10:30 am and 10:50 am, during a bed to w/c transfer by CNA #2</li> </ul>	F 279	<p>1) Residents #2 and #4 had their care plans updated on or before 11/30/16 by IDT with care plan reviewed with resident and/or representative input; and revised as appropriate.</p> <p>2) Residents care plans were reviewed by members of the IDT. Variances between the care plan and resident performance and current restorative and Range of Motion needs were identified with corrections made by the appropriate interdisciplinary team member on or before 12/12/16.</p> <p>3) Prior to close of comprehensive assessments and care area assessments (CAAs), center IDT will review the Care Plan for any additional items, related to restorative range of motion, needing care planned and implement as indicated through review.</p> <p>4) Beginning the week of 11/28/16 the CNE or designee will audit 5 care plans per week for 4 weeks and then audit 2 care plans per week for 2 months to identify discrepancies between the care plan and the resident's performance and needs. The staff member responsible for the care plan discrepancy will be educated at the time of the finding and the care plan will be updated. The results of the audits will be reported in the center QAPI meeting beginning December 2016, with identified negative trends being addressed through education and modification of the PI plan as appropriate.</p>		

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F 279	<p>Continued From page 54</p> <p>* 10/19/16 at 3:45 pm, and 5:45 pm during a w/c to bed transfer by LPN #3 and CNA #8</p> <p>* 10/20/16 at 8:20 am and 10:10 am, during wound care and dressing change by RN #4</p> <p>During the w/c to bed transfer observation on 10/18/16 at 8:50 am, Resident #4 said she felt like a "Yoyo" and CNA #7 said that was because her legs "don't stretch." On 10/19/16 at 5:45 pm, LPN #3 stated, "She's just very contracted."</p> <p>Resident #4's care plan did not include ROM or contractures as focus areas and there were no interventions for ROM in other care plan focus areas.</p> <p>On 10/21/16 at 12:05 pm, RN #4 said Resident #4 was at risk for contractures and that technically everyone is at risk for contractures. RN #4 said Resident #4 should have a care plan for ROM/contractures but she did not.</p> <p>2. Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>The facility failed to fulfill its obligation to provide care that allowed Resident #2 to maintain her highest level of physical, mental, and psychosocial well-being. This resulted in an avoidable decline in functional status, contractures and pressure ulcers as described in the following examples:</p> <p>a. The facility did not initiate an individualized care plan specific to Resident #2, based on</p>	F 279	Reporting will continue for three months or until compliance is achieved.		

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F 279	<p>Continued From page 55</p> <p>comprehensive assessments which identified impaired ROM, development of contractures and pressure ulcers.</p> <p>Resident #2's Annual MDS/CAA, dated 2/10/16, documented upper and lower impairment of ROM on both sides and triggered multiple areas on the CAA. However, they were not addressed on her care plan.</p> <p>The care plan for Resident #2 included a focus area of "Resident has actual skin breakdown related to contractures to left hand. Her care plan was initiated on 10/8/16, and revised on 10/13/16. The care plan documented contractures, however, there was no current care plan developed to address her impaired ROM and mobility.</p> <p>Resident #2's record documented a "Resolved" care plan with a focus of "Resident demonstrates potential for loss/limits with BUE/BLE ROM." The goal for the focus area stated "RESOLVED: Prevent contractures and maintain skin integrity X 90 days." The focus was initiated 2/17/15, revised on 8/18/16, and resolved on 10/6/16.</p> <p>Resident #2's care plan included a "Resolved" care plan with focus of "Restorative Splint and Brace Assistance." The goal for the focus area stated "RESOLVED: Prevent contractures, promote ROM, and maintain skin integrity to res. [resident] left hand X 90 days." The focus was initiated 11/17/15, revised 8/18/16, and resolved 8/18/16.</p> <p>Resident #2's care plan included a focus of "At risk for skin breakdown as evidenced by informed</p>	F 279			

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F 279	<p>Continued From page 56</p> <p>refusal to aspects of care, limited mobility, incontinence, chronic lymphedema, shearing risk, decreased sensation, contractures and use of splint." The care plan was initiated on 12/8/14 and revised on 12/8/15, indicating contractures were evident at that time. The care plan referred to contractures and use of a splint, however, there was no current care plan for contractures.</p> <p>A care plan created on 10/8/16 and revised on 10/13/16, identified the focus of "Actual skin breakdown related to contractures of left hand."</p> <p>On 10/10/16, Resident #2's care plan included an intervention initiated by the DON, which stated, "OT discontinued and recommends use of carrot [orthosis shaped like a carrot] to contracted hand at this time." The intervention did not include details of how often and how long the carrot would be in position, when it would be cleaned, which staff could apply it, or other pertinent information.</p> <p>The care plan did not include a current focus of contractures on Resident #2's right and left hands.</p> <p>b. The facility did not document that Resident #2 or her POA participated in the development of care plans specific to her needs and preferences.</p> <p>The Annual MDS assessment, dated 2/10/16, generated a CAA worksheet dated 2/16/16. The worksheet identified areas of focus, and documented care plans would be developed or revised based on the focus area. The CAA documented resident and family participation with the care planning process, however, the</p>	F 279			

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F 279	Continued From page 57 documentation did not provide clear indication of participation.  Focus area - ADL Functional/Rehabilitation Potential, Pressure Ulcer, Psychotropic Drug Use, Mood/State, and Cognitive Loss/Dementia.  The CAA worksheet included a section titled "Resident and/or Family/Representative." There was no response by the author of the worksheet to indicate Resident #2 or her POA were involved in the development or revision of care plans.  During an interview on 10/21/16 beginning at 10:00 am, the Unit Manager of the Sol Oasis unit reviewed Resident #2's record and stated she could not find a current care plan related specifically to contractures.	F 279			
F 280 SS=E	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	F 280		12/14/16	

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F 280	<p>Continued From page 58 qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were reviewed and/or revised to reflect their current needs. This was true for 7 of 13 (#1, #2, #6, #7, #8, #10, and #12) sampled residents. The deficient practice had the potential to cause harm if residents did not receive appropriate care and treatment due to inaccurate information on their care plans. Findings include:</p> <p>1. Resident #6 was re-admitted to the facility on 10/5/12, with multiple diagnoses, including paranoid schizophrenia, GERD, muscle wasting and atrophy, abnormal posture, anemia, neurogenic bladder, and hypothyroidism.</p> <p>a. An 8/20/16 Quarterly MDS assessment documented Resident #6 exhibited no behaviors or cognitive or decision making impairments, and presented with signs of delusions. The MDS documented Resident #6 did not have range of motion impairments of his lower and upper extremities on either side. In addition, the MDS documented he did not have nutrition related issues and did not reject cares.</p> <p>Resident #6's previous MDS assessments, from December 2015 through May 2016, documented he had range of motion impairments in his lower extremities on both sides.</p>	F 280	<p>280 Care Plan Revision/ Participation</p> <p>1) Residents #1, #2, #6, #7, #8, #10 and #12 -- had their care plans updated on or before 11/30/16 by the IDT to reflect current clinical conditions, choices, and preferences.</p> <p>2) Resident Care Plans were reviewed by members of the center's clinical IDT for accuracy on or before 11/30/16. Any discrepancies identified were corrected at the time of review.</p> <p>3) Care plans will be reviewed by the IDT quarterly; or whenever a change of condition occurs; during the weekly clinical at risk (CAR) meeting, and with the resident and family during quarterly care conferences, or upon resident or representative request, to validate that the care plan accurately reflects the current problems and goals of each resident.</p> <p>4) Beginning of week 11/28/16, members of the clinical interdisciplinary team will conduct an audit of 5 current residents and compile the findings weekly for 4 weeks then monthly for 2 months, to ensure that comprehensive care plans</p>		

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F 280	<p>Continued From page 59</p> <p>b. Resident #6's October 2016 Physician Orders' Review, documented he received Risperdal [antipsychotic] 3 mg at bedtime for paranoid schizophrenia, beginning 8/12/16. Resident #6 had been on Risperdal since his admission to the facility.</p> <p>Resident #6's Impaired Cognitive Function Care Plan, revised 4/3/16, documented he was at risk for a cognitive decline related to behaviors of hallucinations and delusions. The care plan did not include his use of antipsychotic medication. Additionally, the plan did not include the specific, individualized behaviors staff were to monitor Resident #6 for, the type and frequency of monitoring, and interventions staff were to utilize when Resident #6 exhibited the behaviors.</p> <p>Resident #6's Delirium Care Plan, dated 9/23/15, documented he was at risk for symptoms of delirium. The plan stated that when Resident #6 was delusional, staff were to attempt to refocus him to something positive. The care plan did not describe Resident #6's delusions or how they negatively affected him. The care plan did not state how monitoring was to occur, interventions to use if Resident #6 did not respond to efforts to refocus him, and the use of Risperdal.</p> <p>Resident #6's Psychosocial Well-being Care Plan, revised 4/3/16, did not include use of Risperdal or specific behaviors staff were to monitor.</p> <p>Resident #6's Non-Compliance Behaviors Care Plan, revised 4/3/16, documented he declined to participate in cares. The care plan did not include</p>	F 280	<p>have been developed that reflect individualized resident needs based upon the CAA triggers and, as appropriate, are correlated with the Sol-Oasis Resident Needs Monitor form. Findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in December 2016, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p>		

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F 280	<p>Continued From page 60</p> <p>how, or if, Resident #6's noncompliant behavior was to be monitored.</p> <p>Resident #6's Risk of Complications related to Psychotropic Use Care Plan, revised 10/3/16, documented he would have the smallest effective dose without side effects. Interventions included:</p> <ul style="list-style-type: none"> <li>* Monitor for side effects and consult MD PRN.</li> <li>* Staff wew to complete the behavior monitoring flow sheet.</li> </ul> <p>The care plan did not include what the side effects of the medication were. In addition, the care plan did not include the specific psychotropic medication he used or the resident-specific behaviors to be monitored.</p> <p>On 10/20/16 at 9:50 am, the LSW stated the facility monitored for behaviors to include delusion and hallucinations. She stated staff were to monitor all types of delusions and hallucinations, to include dysphoric and happy. She reviewed the care plan and was unable to find instructions for staff to monitor Resident #6's delusions and hallucinations. The LSW was also unable to locate on the care plan, the type of delusions and hallucinations Resident #6 experienced.</p> <p>c. Resident #6's ADL Care Plan, revised 2/29/16, documented he required ADL assistance due to failure to thrive [FTT], with loss of muscle strength, and increased weakness, chronic history of noncompliance with ADL's, and schizophrenia.</p> <p>On 10/20/16 at 11:16 am, the DNS stated she</p>	F 280			

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F 280	<p>Continued From page 61</p> <p>knew Resident #6 had a history of FTT but it was not one of his current diagnoses.</p> <p>2. Resident #7 was admitted to the facility on 10/13/16, with diagnoses which included heart disease, COPD, end stage renal disease, aspiration pneumonia, hospice, sepsis, and dysphagia.</p> <p>Resident #7's Nutrition Care Plan, dated 10/17/16, documented he was at a nutritional risk related to aspiration/necrotizing (death of tissue) pneumonia.</p> <p>On 10/20/16 at 11:40 am, the DNS and RN #4 stated Resident #7 did not have necrotizing pneumonia and the care plan was incorrect.</p> <p>3. Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>Resident #2's care plan did not reflect her current needs, goals, and interventions. Review of Resident #2's current care plan identified areas of focus. However, the care plan did not include measurable goals and relevant interventions to assist Resident #2's achievement of her highest level of physical and psychosocial well-being. Examples include:</p> <p>a. Focus Area: Resident exhibits behavior. Statements of negative feelings regarding self and social relationships characterized by low self esteem and disruptive behavior, such as refusing cares, yells into hallway, and taps on the over</p>	F 280			

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F 280	<p>Continued From page 62 bed tables as a manifestation of her depression.</p> <p>* Goal: "Resident will be encouraged to state trust in one person."</p> <p>* Interventions included:</p> <ul style="list-style-type: none"> <li>- Allow resident time to vent feelings/needs when problematic behaviors are present."</li> <li>- Resident will be encouraged to utilize her call light during instance in which she is yelling out to the hallway for assistance. Staff to ask Resident to push touch pad call light and inform Resident they will return when the light comes on in the hallway. Staff will then return and ask Resident of her needs.</li> <li>- Encourage and teach resident calming techniques.</li> <li>- Document interventions and resident's response to behavior management including, but not limited to, re-approaching when refusing care.</li> <li>- Refer to LSW for continued refusal of care if interventions ineffective.</li> <li>- Sol Oasis program staff will encourage my participation in Neighborhood chat, social group, and other open groups in an attempt for socialization to decrease feelings of sadness and depression.</li> </ul> <p>Resident #2's record documented she was bed bound for greater than 2 years and did not have the ability to socialize in group activities of the Sol</p>	F 280			

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F 280	<p>Continued From page 63</p> <p>Oasis unit. Additionally, her diagnosis of dementia and cognitive impairments compromised her ability to follow the instructions staff were to provide to her. The care plan related to behaviors did not indicate what calming techniques would be taught, and what was effective, to facilitate consistent approaches when providing and reinforcing the techniques.</p> <p>b. Focus Area: ADL Assistance.</p> <p>* Goal: "Resident's ADL care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being." Initiated 12/08/14. Revised 8/18/16.</p> <p>* Interventions included:</p> <ul style="list-style-type: none"> <li>- Side rail X 2 during cares to assist with turning.</li> </ul> <p>During observation of care on 10/18/16 at 10:00 am, side rails were not used and Resident #2 was entirely dependent on the staff for turning in bed.</p> <ul style="list-style-type: none"> <li>- Provide lap blanket at meal times to assist with dignity as she will allow.</li> </ul> <p>Resident #2's record documented she was bed bound for greater than 2 years. During observation of Resident #2's morning meal on 10/18/16 beginning at 9:30 am, her blanket and sheet were drawn up to her chest. The TV was on, and the room remained dark with minimal light coming through the window.</p> <p>c. Focus Area: Resident is at risk for</p>	F 280			

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F 280	<p>Continued From page 64 complications related to the use of psychotropic drugs.</p> <p>* Goal: Resident will have the smallest most effective dose without side effects.</p> <p>Resident #2's MAR did not include psychotropic medications.</p> <p>d. Focus Area: Resident with sleep pattern disturbance as evidenced by insomnia. The care plan was initiated 3/31/15, and was revised on 6/9/16.</p> <p>* Goal: Resident will demonstrate an optimal balance of rest and activity as evidenced by 6-8 hours of sleep per night.</p> <p>Resident #2's record did not include evidence of documentation to ensure this was a measurable goal. There were no sleep tracking records in her record for that time.</p> <p>* Interventions included "Coordinate treatment and medications to limit disruptions at nighttime. Educate resident to limit caffeine intake. Offer sleep medications as ordered at HS.</p> <p>Resident #2's record documented she had dementia, was cognitively impaired, and dependent upon the facility staff for all cares. It was unclear how Resident #2 would be educated about her about caffeine intake. Additionally, Resident #2's MAR did not include medications to induce sleep.</p> <p>During an interview on 10/21/16 beginning at 10:00 am, the Unit Manager of the Sol Oasis unit</p>	F 280			

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F 280	<p>Continued From page 65</p> <p>reviewed Resident #2's record and stated many of the interventions needed to be updated or revised. She stated she could not find documentation of behavior tracking or evidence that behaviors, such as hallucinations or psychosis, were a current problem. The Unit Manager stated that part of Resident #2's care plan should have been resolved. The Unit Manager stated Resident #2 was not on antipsychotic or antidepressant medication, and the care plan should have been resolved. The Unit Manager was When asked if the care plan included measurable goals and appropriate interventions, the Unit Manager stated many of them did not.</p> <p>4. Resident #8 was admitted to the facility on 4/10/15, with diagnosis of non-Alzheimer's Dementia. She was observed on 10/19/16 at 9:50 am, wearing a wander guard on her left ankle.</p> <p>Resident #8's current care plan did not include the wander guard or a reason for its use.</p> <p>5. Resident #10 most current admission to the facility was 4/19/16, with diagnosis of muscle atrophy and contractures to the left foot and right hand.</p> <p>During an interview with Resident #10, on 10/20/16 at 10:30 am, she stated that her right arm was "stiff." She stated that she could not use her right arm and her hand was contracted.</p> <p>Resident #10's care plan had not been revised or updated related to the limitation stated by Resident #10.</p>	F 280			

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F 280	<p>Continued From page 66</p> <p>6. Resident #1 was admitted to the facility on 6/24/13, with a diagnosis of Insulin Dependent Diabetes Mellitus. Care Plan intervention, dated 10/16/14, documented he was to have 1/2 side rails up on his bed to aid in transfers.</p> <p>Observations of Resident #1's bed occurred on 10/17 at 10:50 am, 10/18 at 10:00 am, 10/20 at 7:10 am, and 10/21 at 8:30 am. No side rail was in place during any of the observations.</p> <p>Resident #1's diabetic care plan, dated 10/16/14, documented an intervention for diabetic foot checks daily. The plan stated staff were to observe Resident #1's feet/toes/ankles/soles/heels noting alteration in skin integrity, color, temperature, and cleanliness. Staff were also to check his toenails for shape, length, and color and inspect his shoes for proper fit.</p> <p>On 8/18/16, a physician's order directed treatment to Resident #1's right foot, 4th toe wound. Wound care was ordered every other day. Diabetic foot checks were not completed daily. The plan of care was not updated to reflect this change.</p> <p>A care plan focus for suicidal thoughts and risk for harming self, dated 4/18/16, documented Resident #1 was to be provided meals on paper/plastic utensils.</p> <p>On 10/18/16 at 8:00 am, following the completion of breakfast, a stainless steel knife, fork, and spoon were observed at Resident #1's assigned seat in the dining room.</p>	F 280			

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F 280	<p>Continued From page 67</p> <p>On 10/19/16 at 8:00 am, a stainless steel knife, fork, and spoon were provided to Resident #1. At 5:00 pm the same day, he received silverware with his dinner meal.</p> <p>On 10/20/16 at 7:40 am, the SOPD stated she was not sure who was to update the care plan. She stated it depended on the discipline. She said she was not sure why the care plan called for Resident #1 to receive plastic plates and utensils, or the reason the care plan was not updated.</p> <p>The care plan was not specific as to when staff should provide stainless steel silverware vs. plastic utensils.</p> <p>7. Resident #12 was admitted to facility on 3/12/10, and re-admitted on 9/16/16, following hospitalization for pneumonia. Diagnoses included a history of CVA with right hemiparesis (weakness to right side) and aphasia (speech impairment).</p> <p>A critical care admission note, dated 9/13/16, documented Resident #12 did not move her right upper extremity and it was flexed at the elbow and at the wrist. The note documented Resident #12's hand was closed and she unable to move her hand, most likely secondary to contractures.</p> <p>Resident #12 did not have a plan of care in place reflective of the current contracture of the right hand and arm. Resident #12's care plan for prevention of skin breakdown did not include that her right hand was contracted in a closed fist position. Resident #12's care plan was not</p>	F 280			

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F 280	Continued From page 68 revised or updated to reflect care of the contracture.  Resident #12's record did not include documentation or physician orders addressing her contractures or treatment for contractures of the right upper extremity. The DNS stated Quality of Life rounds were completed weekly with therapy to identify residents that may need therapy or a restorative nursing program. LN #4 and the DNS stated Resident #12 had not received therapy or restorative nursing for her right upper extremity contracture.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 9 sampled residents (#1) when insulin injections were documented as given to a single site. This failed practice created the potential for harm when Resident #1's injection sites were not rotated. Findings include:  The MERCK Manual, a worldwide recognized medical reference, states insulin injections can affect the skin and underlying tissues at the injection site. The Insulin injections may cause fat deposits, making the skin look lumpy, or destroy fat, causing indentation of the skin. Changing the site of injection with each dose generally	F 281	281 Professional Services  1) Resident #1 was assessed by facility RN on or before 11/30/16 for negative outcomes related to multiple administrations of insulin in the abdomen with no negative findings.  2) On or before 12/12/16 Residents who receive regular injections were reviewed by a facility licensed nurse to ensure that rotating injection sites are being used.  3) Residents receiving injections will have the sites added to the MAR to validate that sites are being rotated.	12/14/16	

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F 281	<p>Continued From page 69 prevents these complications.</p> <p>The facility's Medication Administration: Injectable (IM, Sub-Q, Z-Track) policy and procedure, revised 2014, provided direction to administer injections, however, did not provide direction for rotation of site.</p> <p>Resident #1 admitted to the facility on 6/24/13, with multiple diagnoses, including insulin dependent Type 2 Diabetes Mellitis.</p> <p>Resident #1's Physician orders included:</p> <p>* On 9/29/14, an order was written to obtain fingerstick blood glucose before meals and at bedtime.</p> <p>* On 10/28/14, an order for NovoLog insulin 100 units/mL was written to be given based on a sliding scale, a specific dose based on the results of the blood glucose reading, before meals and at bedtime.</p> <p>* On 7/1/15, an order was written for NovoLog 100 units/mL with direction to inject 3 units subcutaneously one time a day at breakfast and 6 units subcutaneously two times daily at lunch and dinner.</p> <p>* On 9/10/16, an order was written for Lantus insulin 100 units/mL with direction to inject 22 units subcutaneously two times a day.</p> <p>Resident #1's MAR for the month of October 2016 reflected the following:</p> <p>* At 6:00 a.m, 18 out of 18 injections were</p>	F 281	<p>Review of orders will occur during morning clinical meeting to validate orders are correct and sites are rotated if indicated by route of administration. Licensed nurses have been educated on or before 11/30/16 by CNE or designee regarding proper documentation of injection site rotation.</p> <p>Beginning the week of 11/28/16 the Medication Administration Record for residents with routine injections will be reviewed five times per week for 4 weeks and then weekly for two months, by the Center Nurse Executive or designee, to ensure that proper rotation of injection sites is occurring.</p> <p>4) Beginning in December 2016 results of these audits will be reviewed in by center's QAPI committee to ensure that proper rotation of injection sites is occurring, with variances to this standard addressed by staff education and negative performance trends addressed with modification of this Plan of Correction. These audits and reviews will continue for three months or until compliance is sustained.</p>		

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F 281	Continued From page 70 documented as given in the "abd", (abdomen.)  * At 8:00 am, 13 out of 18 injections were documented as given in the "abd." 3 doses were held.  * At 12:00 noon, 12 out of 18 injections were documented as given in the "abd." 6 doses were held.  * At 5:00 pm, 8 out of 17 injections were documented as given in the "abd." 6 doses were held.  * At 6:00 pm, 17 out of 17 injections were documented as given in the "abd."  On 10/21/16 at 11:00 a.m, the DNS stated they did not have a system for ensuring the insulin sites were rotated. The DNS stated the facility did not have a system for ensuring rotation of insulin injection sites.	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on review of facility policies, observations, record review, and staff, resident,	F 309	309 Quality of Care	12/14/16	

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F 309	<p>Continued From page 71</p> <p>and POA interviews, it was determined the facility failed to ensure 2 of 9 sampled residents (#1 and #2) received care and services required to meet their highest practicable level of physical, mental, and psychosocial well being. This deficient practice resulted in harm when Resident #2 experienced avoidable development of contractures and pressure ulcers, a decline of ROM, inability to perform ADLs, pain, depression, and social isolation. It also placed Resident #1 at risk of harm due to the facility's failure to assess his abdominal pain and initiate appropriate interventions. These practices had the potential to negatively affect all residents in the facility. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>An Annual MDS assessment, dated 2/10/16, documented Resident #2 was cognitively impaired, bed bound, and fully dependent for all ADLs.</p> <p>A Quarterly MDS assessment, dated 8/8/16, documented Resident #2 was severely cognitively impaired, remained bed bound, and was fully dependent on staff for all her ADLs.</p> <p>On 10/17/16 at 8:20 am, the Unit Manager of the Sol Oasis unit stated Resident #2 was on comfort measures, had bilateral hand contractures, and demonstrated behavior that was described as refusal of cares and self isolating.</p>	F 309	<p>1) Resident #1 had an abdominal assessment completed by licensed nurse on or before 11/30/16 with no abnormal findings. Review of bowel regimen completed with resident at time of assessment. Resident needs met at this time.</p> <p>Resident #2 had an updated clinical nursing assessment to include pain, ROM, contractures, Skin, social isolation and activities by an RN on or before 11/30/16. Comprehensive Assessments were completed and a new Comprehensive Care Plan was developed and implemented by the IDT on or before 11/30/16.</p> <p>2) A review of current resident's pain interviews and/or evaluations was completed by RN on or before 11/30/16 to validate that residents are satisfied with their current level of pain. Practitioners notified as indicated at time of review. New orders were implemented if received and residents and/or their representatives were notified of such orders by the licensed nurse at time of receipt.</p> <p>A review of current resident's bowel movement patterns over the last 7 days was completed by an RN on or before 11/30/16 to identify need for routine or PRN medications and any needed practitioner follow up.</p> <p>Residents without a bowel movement of 3 days or longer had abdominal</p>		

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F 309	<p>Continued From page 72</p> <p>a. Contractures, ROM deficits, and declining ability to perform ADLs.</p> <p>During the 12 month period from October 2015 to October 2016, Resident #2's record documented increasing contractures of both hands and both shoulders. Skin assessment and incident reports for that period documented she experienced recurring pressure ulcers of the left hand as a result of contractures.</p> <p>Resident #2's care plan included interventions related to ADLs. It stated she was dependent for ADL care (bathing, mobility, transfer, locomotion, toileting) due to cognitive loss and compromising functional ability.</p> <p>b. Palliative Care/Comfort Care.</p> <p>Physician progress notes on 10/11/16, documented Resident #2 was receiving palliative care. Her care plan did not include palliative care.</p> <p>c. Pain.</p> <p>The Annual MDS assessment, dated 2/10/16, documented Resident #2's pain intensity rating was "6" on a scale of 1-10.</p> <p>The Quarterly MDS assessment, dated 8/8/16, documented Resident #2's pain intensity was "8".</p> <p>Resident #2's MAR documented she received scheduled Dilaudid 4 mg, TID, as well as, PRN Dilaudid 4 mg, QID. The MAR's documented the Dilaudid for pain was initially ordered 9/23/14.</p> <p>Resident #2's PRN PAIN MANAGEMENT FLOW</p>	F 309	<p>assessments completed by licensed nurse and practitioners were notified as indicated at time of assessment and orders implemented and resident or their representatives were notified. Residents on the SolOasis unit were evaluated by LSW, on or before 11/30/16, to determine whether current plans for psychosocial support are appropriate; and that placement on the unit is appropriate from a person-centered care perspective. Modifications were made as identified.</p> <p>Residents on the SolOasis unit were evaluated by facility RN, on or before 12/12/16, to determine that care provided is appropriate in accordance with each resident's identified clinical need from a person-centered care philosophy including, but not limited to, contractures and range of motion needs.</p> <p>3) System Changes -- Licensed nurse and therapy staff were educated by CNE or designee on or before 12/12/16 on the use of the electronic communication board (24 hour report) to make IDT aware of unresolved issues including but not limited to bowel care, pain management, functional changes, psychosocial concerns and additional needed interventions with dementia residents. Center IDT will review communication board daily during morning clinical review for any items needing additional follow up. Follow up items will be reviewed during end of day clinical stand down for validation of resolution.</p>		

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F 309	<p>Continued From page 73 SHEET was reviewed, and showed the following:</p> <ul style="list-style-type: none"> <li>* The flow sheet for August 2016, documented 9 episodes of requests for additional Dilaudid. Her pain was documented as between 7 and 10 on a 1-10 pain scale.</li> <li>* The flow sheet for September 2016, documented 5 episodes of requests for additional Dilaudid. Her pain was documented as between 5 and 8 on a 1-10 pain scale.</li> <li>* The flow sheet for October 2016, documented 5 episodes of requests for additional Dilaudid. Her pain was documented as between 5 and 7 on a 1-10 pain scale.</li> </ul> <p>Her care plan did not include chronic pain.</p> <p>d. Depression and Social Isolation.</p> <ul style="list-style-type: none"> <li>* One part of Resident #2's care plan, created by the Recreation Assistant on 8/11/16, stated a goal of "...will express satisfaction that her daily routines and preferences are accommodated by staff during inquires. Interventions included "Encourage [Resident #2] to engage in independent leisure and assist with set up as tolerated. Offer 1:1 volunteer visits weekly as tolerated. Having reading materials. Doing things with groups of people, socializing."</li> </ul> <p>The Recreation Assistant did not establish realistic and measurable goals and interventions given Resident #2's bed bound status and inability to go to unit activities. During an interview with her POA on 10/20/16 at 2:00 pm, the POA stated Resident #2 was unable to hold a</p>	F 309	<p>4) Beginning the week of 11/28/16 the resident record will be reviewed by the CNE or designee 5 times weekly for 4 weeks; then 2 times weekly for 8 weeks to validate that documentation in the resident record reflects the completed assignment.</p> <p>Any unresolved concerns will be referred to the appropriate IDT member for resolution.</p> <p>Results of the audits will be presented in the center QAPI meeting for three months (or longer as necessary) beginning in December, with any identified negative trends addressed through system modification and staff education as appropriate.</p>		

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F 309	<p>Continued From page 74</p> <p>book and lacked the ability to concentrate when books on tape were played.</p> <p>Resident #2's record did not include documentation of volunteer visits.</p> <p>Resident #2's "Recreation Activity Logs" for August 2016, documented 8 individual visits. September 2016, documented 5 individual visits. October 2016 documented 4 individual visits.</p> <p>During an interview with Resident #2's POA on 10/20/16 at 2:00 pm, she stated that in the past, she was able to visit Resident #2 frequently, from 4 times weekly to daily visits. She stated due to a health crisis of another family member, she was unable to visit more than once weekly. She stated she felt that her decreased visit frequency contributed to Resident #2's isolation and depression.</p> <p>* Resident #2's room was located on the Sol Oasis unit. On 10/18/16 at 1:45 pm, the Sol Oasis Program Director (SOPD) described the function of the program. She stated the program provided extra support and life skills for residents 7 days a week and was a transitional program for residents that had a goal of returning home. The SOPD stated the program was aimed at younger residents, many of who may have a psychiatric diagnoses. She described the program as voluntary, with activities of coping, positive choices, and providing 1:1 visits with residents. She stated the program was able to facilitate a clinical liaison in the community for counseling needs. The SOPD stated Resident #2 was admitted approximately 3 years ago from another facility. She stated her mental and physical</p>	F 309			

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F 309	<p>Continued From page 75</p> <p>health had declined, and she felt the program would provide her with extra socialization above and beyond what the facility offered for non-Sol Oasis residents. The SOPD stated all residents in the facility received recreation and volunteer visits. When asked what the Sol Oasis program visits for Resident #2 included, she stated they were mostly 1:1 visits which were called "You and Me" visits.</p> <p>* Sol Oasis Participation Logs were reviewed. From 9/14/16 to 10/17/16, the log included 7 entries for Resident #2. The entries included a haircut, discussion of her love of Disney, she was consoled during a crying episode, she was brought candy from a run to the store, (2) You and Me activities, and was provided support during a Podiatry procedure.</p> <p>e. Refusal of Care:</p> <p>On 10/17/16 at 10:15 am, Resident #2 was observed as she was offered scheduled medications, which included Dilaudid. She refused the medication, and refused the attempts of RN #1 to assess her left hand. Resident #2 said "No, no, no," repeatedly in a high pitched voice when her left hand was touched by RN #1.</p> <p>Resident #2's August, September, and October 2016 MARs and TARs included documentation of instances when she refused cares and medications. Additionally, her care plan reflected interventions related to how staff would approach Resident #2 when her behavior resulted in refusal of cares or medications.</p> <p>On 10/18/16 at 2:50 pm, RN #1 reviewed</p>	F 309			

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F 309	<p>Continued From page 76</p> <p>Resident #2's record and stated she often refused care. She described instances of refusal for assistance with turning in bed, medication administration, use of splints for contractures, and getting out of bed. She stated all residents were able to refuse care, but [Resident #2] was on comfort care, so she refused medications and cares often. RN #1 was unable to find care plans related to comfort care or chronic pain in Resident #2's record. Additionally, RN #1 was unable to find formal documentation of Resident #2 being placed on comfort care. She stated "it has been more than a year."</p> <p>The facility failed to provide comprehensive assessments and appropriate interventions for Resident #2's physical, mental, and psychosocial needs. The cumulative effect resulted in unaddressed chronic pain, contractures, pressure ulcers, and increased social isolation.</p> <p>2. Resident #1 was admitted to the facility on 6/24/16, with diagnoses of schizoaffective disorder, bipolar disorder, depression, anxiety, and obsessive compulsive disorder.</p> <p>A Quarterly MDS, dated 9/20/16, documented Resident #1 was cognitively intact.</p> <p>A Care Plan Focus, dated 4/18/16, documented Resident #1 had expressed suicidal thoughts and was at risk for harming himself related to depression and persistent negative statements. Interventions initiated on 9/15/16, documented Resident #1 focused on fears related to his bowel movements. When this occurred staff were to redirect him to a positive conversation.</p>	F 309			

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F 309	<p>Continued From page 77</p> <p>On 6/14/16 at 6:26 pm, a Nurses' Note documented Resident #1 was, "continually stating that he has a bad bowel sensation."</p> <p>On 6/20/16, a Nurse Practioner documented Resident #1 stated that he had regular bowel movements daily but after going still felt the urge to defecate throughout the day. The Nurse Practioner noted that staff stated this had been an ongoing chronic problem for quite some time. The Nurse Practioner documented Resident #1 had been seen by a gastroenterologist, "even undergoing a colonoscopy" and no pathology was found.</p> <p>On 7/22/16, the facility received a physician's order for Colace 100 mg two times a day.</p> <p>On 9/17/16, Benefiber powder, one tablespoon daily, was discontinued although Resident #1 continued to receive it through 9/29/16.</p> <p>A bowel care protocol was put in place on 9/29/14, which included:</p> <ul style="list-style-type: none"> <li>* Give Milk of Magnesia 30 mLs at bedtime when there has been no bowel movement for three days. If no result from Milk of Magnesia, give a Dulcolax suppository on the next shift.</li> <li>* If no results from the suppository within 2 hours, provide a Fleets enema.</li> <li>* Call MD if no results from Fleets enenam.</li> </ul> <p>CNA Flowsheets for the month of September 2016, documented Resident #1 did not have a bowel movement 9/2/16 through 9/5/16. No</p>	F 309			

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F 309	Continued From page 78 documentation was found that indicated the bowel care protocol was initiated. Further, no documentation was found in Nurses' Notes to indicate there was a concern, interventions were initiated, a physical assessment completed, or that the physician was notified.  On 9/12/16 at 5:53 pm, a Social Service note, completed by the LSW, documented Resident #1 stated he was suffering and wanted to have a bowel movement but could not. The LSW documented that Resident #1 said that if he had a sharp object he would end the suffering and take his life.  Resident #1 was transferred to the ER for voicing suicidal thoughts. A nursing assessment completed prior to, or upon return from, the ER, was found in Resident #1's medical record	F 309			
F 312 SS=D	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 record review, and staff and POA interviews, it was determined the facility failed to ensure 1 of 9 (#2) sampled residents whose ADL care was reviewed, received assistance with bathing, as directed by her plan of care. This deficient practice placed Resident #2 at risk of psychosocial harm due to lack of hygienic	F 312	312 ADL Care of Dependent Residents  1) Resident #2 received assistance with bathing and hygiene by CNA on or before 11/30/16. Resident satisfied with assistance provided.	12/14/16	

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F 312	<p>Continued From page 79 practices. Findings include:</p> <p>Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>Resident #2's ADL Care Plan, dated 12/8/14, documented she was dependent on staff for ADL assistance, which included dressing, grooming, toileting, eating, bed mobility, and bathing.</p> <p>A CNA task sheet in a CNA binder on the Sol Oasis unit documented residents' bath day assignments. Resident #2 was assigned to bathe each Tuesday on the day shift, and each Friday on the night shift.</p> <p>A POC Legend Report was provided by the DNS on 10/19/16. The report included codes which, when compared to the ADL flow sheet, identified the task performed, the resident's tolerance, and who completed the task.</p> <p>The ADL flow sheet for September documented Resident #2 received a bath on 9/20/16 and 9/27/16.</p> <p>The ADL flow sheet for October documented Resident #2 received a bath on 9/27/16 and 10/2/16.</p> <p>The ADL flow sheets for September and October included a code of -97 on the remaining designated Tuesday and Friday bath days.</p> <p>The POC Legend Report documented code -97</p>	F 312	<p>2) Residents were reviewed and interviewed by IDT members on or before 11/30/16 for evidence that ADL support, including bathing and hygiene needs are met. Any deficient practice was corrected at the time identified with staff education provided.</p> <p>3) Nursing Staff have been educated by CNE or designee on or before 11/30/16 regarding the requirement to provide ADL support as found in 42 CFR §483.25(a)(3).</p> <p>4) Beginning the week of 11/28/16 members of the center IDT will complete center rounds and review bathing documentation to ensure compliance with 42 CFR §483.25(a)(3). Rounds will be completed 5 times weekly for 4 weeks; then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time referred to a Center Nurse Manager for resolution.</p> <p>Results of the rounds will be presented in the center QAPI meeting, by the CNE or designee, for three months (or longer as necessary) beginning in December, with any identified negative trends addressed through system modification and staff education as appropriate.</p>		

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F 312	Continued From page 80 indicated "Not Applicable."  10/19/16 at 2:00 pm, Resident #2's POA stated she did not know when the bathing activities took place, but noticed Resident #2's hair frequently appeared "greasy and uncombed."  On 10/21/16 at 2:00 pm, the Unit Manager of the Sol Oasis unit reviewed the ADL flow sheets and stated the code of -97 "probably meant that she [Resident #2] refused the activity." She stated Resident #2 was able to refuse cares.  The facility did not provide adequate bathing assistance to Resident #2.	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 resident and staff interviews, it was determined the facility failed to ensure the necessary nursing care and services were provided to promote the healing of pressure ulcers, and to prevent pressure ulcers from reoccurring after they were healed. This was true for 3 of 3 (#2, #3 and #5)	F 314	314 Pressure Sores  1) Resident #2's pressure injury was assessed by center's skin integrity coordinator on or before 10/28/16 with no negative findings including but not limited to worsening or signs and symptoms of	12/14/16	

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F 314	<p>Continued From page 81</p> <p>sampled residents reviewed for pressure ulcers. Resident #2 was harmed when the facility failed to ensure interventions were utilized to prevent contractures of her hand that resulted in recurrent pressure ulcers. Residents #3 and #5 were at risk of harm related to the facility's failure to promptly assess existing pressure ulcers, and implement interventions. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>Resident #2 experienced an avoidable decline in functional status, contractures, and pressure ulcers as described in the following examples:</p> <p>a. An OT Evaluation, dated 12/8/15, documented contractures, and impaired mobility of both upper extremities and shoulders.</p> <p>In the section Integumentary, the OT Evaluation stated, "...at huge risk for skin breakdown as pt [patient] does not get out of bed and is unable to re-position herself."</p> <p>The section of the OT Evaluation titled Assessment Summary, documented, "...all digits on L hand are separated with no risk of skin breakdown due to fingers overlapping or nails digging into palm of hand."</p> <p>A Progress Note, dated 12/8/15, documented a therapeutic carrot [orthosis shaped like a carrot] was discontinued after LPN #5 conferred with the occupational therapist. The progress note stated</p>	F 314	<p>infection. Skin integrity report was updated at time of assessment.</p> <p>Resident #3's pressure injury was assessed by center's skin integrity coordinator on or before 10/28/16 to validate appropriate treatment and interventions, with no negative findings including but not limited to worsening or signs and symptoms of infection. Skin Integrity Report was updated at time of assessment. The care plan was reviewed and updated to reflect the current treatment and interventions as appropriate.</p> <p>Resident #5's pressure ulcer was assessed by center's skin integrity coordinator on or before 10/28/16 for appropriate treatment and interventions to promote healing with no negative findings including but not limited to worsening or signs and symptoms of infection. Skin integrity report was updated at time of assessment. The resident was given a bigger bed to promote optimal positioning. Education was provided to the resident on bed positioning to include head of bed elevation.</p> <p>2) A review of current residents with in-house acquired pressure ulcers as well as residents that admitted in the past 30 days with a pressure injury was completed by RN on or before 11/30/16 to validate that wound assessments were completed at time of admission and/or</p>		

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F 314	<p>Continued From page 82</p> <p>a sheep skin palm protector splint was applied to Resident #2's left hand to assist with maintaining skin integrity and to help prevent continued contracture formation.</p> <p>A communication form to Resident #2's physician titled CHANGE OF STATUS, was dated 12/9/15. The form stated, "Due to contractures and facility attempts to offload contracted areas, skin breakdown unavoidable at this time."</p> <p>Resident #2's Annual MDS assessment, dated 2/10/16, documented impaired cognition, impaired mobility, and contractures. Section M of the MDS documented Resident #2 was at risk of developing pressure ulcers. The analysis of findings in Resident #2's pressure ulcer CAA worksheet, dated 2/16/16, documented she was, "...at risk for skin concerns."</p> <p>A form titled Skin Integrity Report, described a pressure ulcer on Resident #2's left hand. It was initiated on 4/5/16. The report described the pressure ulcer as Stage II. The pressure ulcer was documented as becoming 100% epithelialized by 4/18/16. Further weekly assessments noted the area was healed as of 6/27/16.</p> <p>A Physician's order, dated 4/8/16, requested an OT evaluation for "skin impairment" of left hand.</p> <p>A form identified as Skin Check.-V 1, dated 4/05/16, included documentation of a bruise on Resident #2's left hand forefinger with a small open area. The wound was documented as a pressure wound.</p>	F 314	<p>onset of wound, skin integrity reports were initiated at time of admission or onset of wound, preventative measures and treatments are in place, and care plan updated. A review was also completed by RN on or before 11/30/16 of current residents residing in the center without wounds, to validate preventative measures in place and that weekly skin checks are occurring. No corrections needed at time of review. Care plans updated as indicated at time of review.</p> <p>3) Residents will be reviewed during morning clinical meeting if pressure injury is newly identified or present on admission, and whether risks for pressure injury are identified on admission. For those with wounds, center IDT will validate that a skin integrity report has been initiated, treatment is in place, and family and provider are aware of current skin integrity. Licensed nursing staff were re-educated on or before 12/12/16 regarding Pressure Injury prevention, identification, and treatment protocols.</p> <p>4) Beginning the week of 11/28/16, members of the IDT Management will conduct audits of 5 current resident's with pressure ulcers and/or palliative goals to identify skin integrity changes and/or non-compliance with preventive measures or treatments including pressure related to contractures and contracture management devices, such as splints.</p>		

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F 314	<p>Continued From page 83</p> <p>The wound was documented on the Skin Check forms on 4/12/16 and 4/19/16.</p> <p>On Skin Check forms dated 5/3/16, 5/10/16, 5/17/16, and 5/24/16, Resident #2's left forefinger was documented as bruised.</p> <p>A Skin Check form, dated 5/31/16, documented a small callused area on the left forefinger.</p> <p>In a Quarterly MDS assessment, dated 8/8/16, Resident #2 was documented to be at risk of developing pressure ulcers. The assessment did not identify the resolved pressure ulcer of her left hand that was noted on 4/5/16.</p> <p>A Skin Check form, dated 8/9/16, documented Resident #2 had small open areas on her left hand between her thumb and forefinger. It stated the finger brace may be rubbing in that area. It was documented as a Stage II pressure ulcer.</p> <p>An OT Discharge Summary, dated 10/10/16, documented Resident #2 was discharged from OT with a left hand carrot splint to be used for skin integrity.</p> <p>A form titled Skin Integrity Report, described the pressure ulcer on Resident #2's left hand. It was initiated on 10/7/16, and documented additional skin assessments on 10/11/16 and 10/17/16. The report documented the pressure ulcer as unstageable.</p> <p>A Skin Check form, dated 10/11/16, documented "Noted creamy yellow matter to hand. Resident declining to open hand to be evaluated."</p>	F 314	<p>Beginning the week of 11/28/16, members of the nurse management team will conduct a review of 5 new admissions for the proper initiation and implementation of the center skin integrity protocol each week for 4 weeks then 5 residents monthly for 2 months.</p> <p>The Director of Nursing or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required.. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in December 2016, the compiled results will be presented by the CNE during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p>		

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F 314	<p>Continued From page 84</p> <p>On 10/18/16 at 3:25 pm, Resident #2's left hand was observed during cares. RN #1 and the Unit Manager of Sol Oasis unit, also an RN, removed the soft splint from her hand. Measurements were obtained, and the contractured hand was cleansed. Her left hand was fistled, with the left forefinger tucked tightly into the web area between her thumb. The 2 RN's were unable to open Resident #2's hand to inspect for long fingernails or further skin impairments of the rest of her hand.</p> <p>Resident #2's left hand also had a large crusty finger-like growth, which the Unit Manager called a skin tag. It was in the knuckle area between her left third and fourth fingers and extended out approximately 1.5 cm.</p> <p>On 10/18/16 at 2:50 pm, RN #1 described the progression of Resident #2's contractures. She stated when Resident #2 was admitted 3 years ago, she was not able to fully open her hands, but she was able to hold utensils. Shortly after that, she was provided with specially designed utensils, and still required assistance with activities such as eating. RN #1 stated Resident #2 had the contractures for approximately a year, worse on her left shoulder, elbow and hand, and developing on her right. She stated the pressure ulcers in that area were recurring.</p> <p>2. Resident #3 was admitted to the facility on 9/28/16, with multiple diagnoses including vertebral compression fracture and acute pain.</p> <p>Resident #3's 10/5/16 admission MDS assessment documented intact cognition and 1 unstageable PU present on admit.</p>	F 314			

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F 314	<p>Continued From page 85</p> <p>The PU CAA Worksheet, dated 10/6/16, documented, "...pressure area to spine related to kyphosis and decreased mobility due to vertebral fractures."</p> <p>Care plan focus areas included the risk for skin breakdown related to impaired mobility, initiated 9/29/16; and, actual skin breakdown, pressure injury noted on admit, initiated 10/4/16, six days after Resident #3 was admitted to the facility.</p> <p>Resident #3's Transfer Orders/Instructions, dated 9/27/16, contained the handwritten entry, "Wound care[:] Mepilex Santyl once daily spine 9/28/16."</p> <p>A Progress Note, dated 9/28/16 at 6:30 pm, documented Resident #3 was admitted to the facility with a Braden score of 18, indicating she was at risk of pressure ulcers; and, "See nursing admission assessment (UDA) for detailed clinical findings."</p> <p>A "Nursing Assessment - Initial (Admission) v3," dated 9/29/16 (one day after admit), documented, "Kyphosed back, wounds to bony prominences, dressed with border gauze." It did not include a comprehensive assessment of the wound and no other UDA regarding the back wound was found in Resident #3's EMR or paper chart.</p> <p>On 10/21/16 at 8:20 am, RN #7 was observed as she provided wound care and dressing change per orders to Resident #3's mid-spine PU. The RN did not measure the PU and said measurements were obtained earlier in the week. The RN said the PU was "about the same" as</p>	F 314			

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F 314	<p>Continued From page 86</p> <p>when the resident was admitted. The PU was approximately 3 cm long by 2 cm wide with a film of pale yellow slough over 3/4 of the wound bed and deep purple/red color to the surrounding skin.</p> <p>On 10/21/16 at 9:00 am, RN #3, who identified herself as the Skin Integrity Coordinator, provided Resident #3's "Skin Integrity Report" which included "Weekly Data Collection." The Report documented 9/28/16 as the "Initial Wound Date" for the mid-spine unstageable PU with slough. The Report documented comprehensive assessments were completed on 10/5/16, 10/11/16, and 10/19/16. The Report did not include a comprehensive assessment for 9/28/16 or 9/29/16. In addition, the 10/5/16 and 10/11/16 assessments documented the PU wound bed was 100% slough and the depth was "&lt; 0.1" cm." RN #3 said she was instructed to document "less than 0.1 cm" when the wound bed was covered with slough or eschar because "we know the skin is broken." RN #3 looked for a UDA related to the 9/29/16 initial nursing assessment and said she did not find anything. The RN said she would keep looking.</p> <p>On 10/21/16 at 11:30 am, RN #3 provided a 9/26/16 Wound Care Progress Note (2 days before Resident #3's admission to the facility), which documented an initial consult for a wound on Resident #3's mid back/thoracic spine area and, "Unstageable pressure ulcer...mid back/spine bony prominence...measures 3.7 x 2.2 cm, with an area of well-adhered yellow slough in the center measuring 2.2 x 1.1 cm. Depth is undetermined..." The facility did not provide other documentation regarding the PU.</p>	F 314			

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F 314	<p>Continued From page 87</p> <p>3. Resident #5 was admitted to the facility on 9/6/16, following a right BKA due to a right heel pressure ulcer with development of wet gangrene.</p> <p>An MDS assessment, completed on 9/13/16, documented Resident #5 was cognitively intact, had a stage 4 pressure ulcer to the sacral region, and required extensive assistance of staff for bed mobility, transfers, and toileting.</p> <p>A Care Plan Focus, dated 9/7/16, documented Resident #5 required assistance/was dependent on staff bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting.</p> <p>A Care Plan Focus, dated 9/8/16, documented Resident #5 was at risk for skin breakdown. Interventions in place included repositioning every two hours as Resident #5 allowed, offloading pressure points as he allowed, and utilizing positioning devices, as appropriate, to prevent pressure over bony prominences.</p> <p>A Physician's order, on 9/6/16, documented the use of a foam dressing under negative pressure wound vacuum for treatment of the Stage 4 pressure ulcer to sacrum.</p> <p>CNAs documented turning and repositioning Resident #5 every 2 hours as he allowed, on a flowsheet. From 10/1/16 through 10/17/16 there were 204 opportunities to turn Resident #5. Of the 204 opportunities, 36 did not include documentation that Resident #5 was turned or repositioned. The remaining 168 opportunities</p>	F 314			

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F 314	Continued From page 88 had a "Y" documented signifying Resident #5 was turned or repositioned every 2 hours around the clock.  On 10/17/16 at 1:10 pm, Resident #5 was lying on his back on a low air loss bed. The head of the bed was raised placing him in a sitting position. The sole of his left foot was flat against the footboard of the bed.  On 10/18/16 at 9:50 am, Resident #5 was lying on his back with the head of the bed raised to enable a sitting position.  On 10/18/16 at 1:15 pm, Resident #5 was lying on his back. Upon interview, Resident #5 stated "No, they have not offered to reposition or turn me every two hours. They turn me when I use the bedpan. This bed does not have a lot of room." His left foot was flat against the footboard.  On 10/20/16 at 10:00 am, Resident #5 was lying on his back with the head of bed raised to a sitting position. He stated, "They tried turning me last night. It didn't work too good. I felt like I was going to roll off the bed. I think they are going to try to get me a bigger bed."	F 314			
F 318 SS=G	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 range of motion and/or to prevent further decrease in range of motion.	F 318		12/14/16	

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F 318	<p>Continued From page 89</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined the facility failed to ensure residents with limited range of motion and contractures received necessary services to prevent further decline in ROM. This affected 5 of 6 (#2, #4, #5, #9 and #12) residents sampled for limited ROM. Resident #2 was harmed when the facility failed to recognize functional decline and prevent further loss of mobility, which resulted in increased depression, withdrawal, social isolation and pressure ulcers. The failure also created the potential for further decline in the functional range of motion for Residents #4, #5, #9, and #12.</p> <p>1. Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>Resident #2 had recurrent pressure ulcers in her left hand, which were documented as a result of contractures. On 10/20/16 at 11:00 am, the Administrator provided a packet of Resident #2's medical record forms, which he identified as a time line for the development of her contractures. The timeline included:</p> <p>a. The first entry on the time line was 10/27/15, in which a physician's order was obtained for an OT evaluation.</p> <p>An OT Evaluation was completed on 11/4/16. The OT Discharge Summary, dated 11/18/16,</p>	F 318	<p>318 Range of Motion Treatment and Services</p> <p>1) Residents #2, #4, #5, #9, #12 were assessed for range of motion by UM on or before 11/30/16. Therapy orders received and evaluations completed on or before 11/30/16.</p> <p>2) A review of other residents residing in the center was completed by members of the nurse management team on or before 11/30/16 for contractures and need for ROM, and/or therapy and RNA services. RNA programs and therapy orders were established as indicated through review.</p> <p>3) Residents will be reviewed quarterly during quality of life (QOL) rounds with CNA, nursing, and therapy for any needed interventions or declines from previous quarter. Orders will be requested as indicated through review and care plans updated with any changes. Results of QOL rounds will be discussed during the weekly CAR meeting to ensure follow-up on identified concerns.</p> <p>4) Beginning the week of 11/28/16 CNE or designee will conduct an audit of 5 residents per week for four weeks and 2 residents per week for 2 months to ensure residents are receiving RNA services. Beginning in December 2016 the results of these audits will be</p>		

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F 318	<p>Continued From page 90</p> <p>documented Resident #2 was issued a right side palm protector and a left hand carrot splint to prevent further contractures. An RNP program was initiated, with the focus of preventing further contractures, skin breakdown, to maintain splinting and provide PROM for left fingers.</p> <p>Resident #2's record documented an RNP program was initiated, with the focus of preventing further contractures, skin breakdown, to maintain splinting, and provide PROM for left fingers. She received RNP services from 11/17/15 to 2/23/16.</p> <p>The RNP interventions were not clearly defined. They did not include the frequency the RNP activities would occur, or provide PROM as was planned by the Occupational Therapist as she indicated on the discharge summary.</p> <p>Dates of RNP activities provided to Resident #2 were inconsistent and sporadic as follows:</p> <ul style="list-style-type: none"> <li>* 11/17/15 to 11/30/15, 3 sessions,</li> <li>* 12/01/15 to 12/31/15, 11 sessions,</li> <li>* 1/1/16 to 1/31/16, 9 sessions, (PROM was added to the RNP record beginning 1/5/16.)</li> <li>* 2/1/16 to 2/24/16, 8 sessions.</li> </ul> <p>b. The timeline documented an OT Evaluation, dated 12/8/15. It documented Resident #2 had contractures and impaired mobility of both upper extremities and shoulders.</p> <p>In the section "Integumentary," the OT Evaluation</p>	F 318	presented by the CNE during the QAPI committee meeting monthly for a minimum of 3 months or until compliance is sustained, with revision to the performance improvement plan as necessary for continued improvement.		

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F 318	<p>Continued From page 91 stated "...at huge risk for skin breakdown as pt [patient] does not get out of bed and is unable to re-position herself."</p> <p>The section of the OT Evaluation titled "Assessment Summary," documented "...all digits on L hand are separated with no risk of skin breakdown due to fingers overlapping or nails digging into palm of hand."</p> <p>c. A Progress Note dated 12/8/16, documented the carrot splint was discontinued after LPN #5 met with the occupational therapist. The progress note stated a sheep skin palm protector was applied to her left hand to assist with maintaining skin integrity and to help prevent continued contracture formation.</p> <p>d. Resident #2's Annual MDS assessment dated 2/10/16, documented impaired cognition, impaired mobility, and contractures. Section M of the MDS documented Resident #2 was at risk of developing pressure ulcers. The analysis of findings in the resident's PU CAA worksheet, dated 2/16/16, documented, "...at risk for skin concerns."</p> <p>e. A Physician order dated 4/8/16, requested an OT evaluation for "skin impairment" of left hand.</p> <p>* OT therapy performed an evaluation on 8/9/16, and goal stated was "Pt will be referred to orthotist for splinting needs related to contractures.</p> <p>* An OT Discharge Summary, dated 10/10/16, documented Resident #2 was discharged from OT with her left hand carrot splint to be used for</p>	F 318			

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F 318	<p>Continued From page 92 skin integrity.</p> <p>10/18/16 at 3:25 pm, Resident #2's left hand was observed during cares. RN #1 and the Unit Manager of Sol Oasis unit removed the soft splint from her hand. Measurements were obtained, and the contractured hand was cleansed. Her left hand was fistled, with the left forefinger tucked tightly into the web area between her thumb. The 2 LN's were unable to open her hand to inspect for long fingernails or further skin impairments of the rest of her hand.</p> <p>On 10/19/16 at 2:30 pm, Resident #2 was heard calling for help. Upon receiving permission to enter the room, she asked the surveyor to scratch her forehead. Resident #2 was encouraged to perform the task herself. She was able to bring her head forward, and right arm up towards her face, and rubbed her forehead with a knuckle of her curled right hand. She was then asked if it was possible to open her hand, and was able to open it slightly as to form a cup. She stated it could not open any further.</p> <p>On 10/18/16 at 2:50 pm, RN #1 described the progression of Resident #2's contractures. She stated when Resident #2 was admitted 3 years ago, she was not able to fully open her hands, but she was able to hold utensils. Shortly after that, she was provided with specially designed utensils, and still required assistance with activities such as eating. RN #1 stated Resident #2 had the contractures for approximately a year, worse on her left shoulder, elbow and hand, and developing on her right. She stated the pressure ulcers in that area were recurring. RN #1 stated Resident #2 was on "Comfort Care," and refused</p>	F 318			

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F 318	<p>Continued From page 93 much of her care, including wearing of the splints.</p> <p>On 10/20/16 at 2:52 pm, OT #1 stated Resident #2 was not cognitively able to understand why she needed to be compliant with wearing the splints, She stated Resident #2 frequently refused to wear the splint, and the staff was instructed to contact the LSW when she refused.</p> <p>OT #1 was questioned why 3 OT evaluations were performed, however, the entire body was not assessed for decline in mobility or ROM. She stated the paper physician's order read "OT Eval and treat," however, she received verbal communication from the nursing staff to evaluate contractures in the left hand. She stated the OT Evaluations were focused on the left hand.</p> <p>OT #1 stated Resident #2 was documented as having decreased ROM of both upper extremities on the evaluation, dated 12/8/16, because the immobility was due to her morbid obesity, not contractures.</p> <p>The facility failed to prevent contractures for Resident #2, the contractures continued to decline over a 1 year period which resulted in pressure ulcers, inability to feed herself and perform ADLs.</p> <p>2. Resident #4 was initially admitted to the facility in 2007 and readmitted in 3/11/15, with multiple diagnoses including dementia, hemiplegia and hemiparesis related to a CVA, muscle weakness, muscular wasting and disuse atrophy and difficulty walking.</p>	F 318			

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F 318	<p>Continued From page 94</p> <p>Resident #4's 10/1/16, quarterly MDS assessment documented moderate cognitive impairment, functional limitation in ROM in one upper and one lower extremity, OT services between 6/23/16 and 7/14/16, PT services between 1/29/16 and 2/8/16, and that a restorative nursing program was not provided.</p> <p>Resident #4's 7/1/16 quarterly MDS assessment, differed from the 10/1/16 assessment, in that no functional limitations in ROM were noted in either the upper or the lower extremities and OT services were provided for 5 days beginning on 6/6/16.</p> <p>Resident #4's 3/23/16 annual MDS assessment, differed from the 7/1/16 MDS assessment, in that OT services were provided for 4 days beginning on 2/29/16 and PT services were provided between 1/29/16 and 2/8/16. Again, a restorative nursing program was not provided.</p> <p>Resident #4 was observed with her right leg angled forward and both knees bent at a 90 degree angle on:</p> <ul style="list-style-type: none"> <li>* 10/17/16 at 1:25 pm</li> <li>* 10/18/16 at 8:50 am, during a w/c to bed transfer by CNA #7</li> <li>* 10/18/16 at 9:00 am, 9:30 am, and 9:55 am to 10:15 am, during direct care and repositioning in bed by the DNS and RN #4, and at 11:15 am, 1:35 pm, 2:20 pm and 3:30 pm</li> <li>* 10/19/16 at 10:30 am, at 10:50 am during a bed to w/c transfer by CNA #2</li> <li>* 10/19/16 at 3:45 pm, and at 5:45 pm during a w/c to bed transfer by LPN #3 and CNA #8</li> <li>* 10/20/16 at 8:20 am and 10:10 am, during</li> </ul>	F 318			

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F 318	<p>Continued From page 95 wound care and dressing change by RN #4.</p> <p>During the w/c to bed transfer observation on 10/18/16 at 8:50 am, Resident #4 said she felt like a "yoyo" and CNA #7 said that was because her legs "don't stretch."</p> <p>On 10/19/16 at 5:45 pm, prior to transferring Resident #4 from the w/c to bed, LPN #3 stated, "She's just very contracted."</p> <p>There was no care plan for ROM or contractures and there were no interventions for ROM in other care plan focus areas.</p> <p>RNA Progress Notes/Summary for August and September 2015, contained repeated documentation that Resident #4 liked the RNP and participated willingly. However, a 9/2/15 entry documented, "Unable to see today, RNA on the floor" and a 9/22/15 entry documented, "Res[ident] dc'd per her request." There were no entries prior to that about Resident #4 refusing to participate, or requesting to stop, the RNP.</p> <p>Restorative Nursing Records for September 2015 documented, "Unable to see - floor CNA" on 9/2/15 and "Unable to see," without explanation, on 9/14/16.</p> <p>RNA Progress Notes/Summary for February and March 2016, documented Resident #4 still liked the program but participated less and less during each session and required frequent to constant cueing.</p> <p>Resident #4's Restorative Nursing Records for February and March 2016 documented "Unable</p>	F 318			

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F 318	<p>Continued From page 96 to see" on 2/16/16, 2/22/16, 2/23/16, 3/1/16, 3/2/16, 3/7/16, 3/8/16 and 3/14/16 without explanation. Additionally, across 3/15/16 and 3/16/16 was documented "DC," again without explanation.</p> <p>On 10/21/16 at 11:10 am, PT #1 said she was very familiar with Resident #4 and the resident had a significant decline prior to her readmission in 2015. The PT said Resident #4 had genu valgum of the right hip (inward rotation) that was caused by abnormal posture and abnormal muscle tone (hypertonicity) as opposed to contracture. The PT said that consistent ROM "wouldn't hurt" and could be beneficial from a human touch perspective but it would not change the spasticity.</p> <p>On 10/21/16 at 12:25 pm, LPN #4 said she was over the RNP. LPN #4 said Resident #4 may have been discontinued from the RNP in March 2016, because the facility had only one "official" RNA. LPN #4 said the RNA worked four days a week and there were times the RNA may have been "pulled" to work the floor instead of the RNP.</p> <p>3. Resident #9 was admitted to the facility on 5/13/15, with a diagnosis of paraplegia and muscle wasting.</p> <p>During an interview on 10/17/16, at 11:05 am, Resident #9 stated that her left shoulder had an injury and she now had limited ability to use her arm. She said she was left handed and unable to do her normal activities, such as sewing or personal care because of this injury. She said until recently she could still sew but was not able</p>	F 318			

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F 318	<p>Continued From page 97</p> <p>to use her arm at this time. When questioned, she stated that she did not receive Physical Therapy or Restorative Nursing therapy. Resident #9 identified that to support her left arm and hand, she pulled on her sleeve to hold it up (demonstrating this procedure) and that doing that helped with pain.</p> <p>The Restorative Nursing Program notes for Resident #9 documented a lower extremity range of motion program (undated or signed) but there was no restorative program for her left upper extremities. During an interview with OT #3 on 10/20/16 at 3:00 pm, OT #3 stated that the only therapy Resident #9 was receiving was for her lower extremities.</p> <p>4. Resident #5 was admitted to the facility on 9/6/16, following a right BKA due to a right heel pressure ulcer developing wet gangrene.</p> <p>The Physical Therapy Initial Evaluation, dated 9/6/16, was completed in Resident #5's room because of C-Diff precautions. The evaluation documented the frequency of visits was to be 5 times a week. Between 9/7/16 and 10/19/16, Resident #5 received physical therapy 15 times, 9 visits in September and 6 visits in October. No documentation was found addressing ROM to his right knee/right lower extremity.</p> <p>On 9/22/16 at 4:07 pm, a Treatment Encounter Note (TEN) documented, "Seated lower extremity exercises with 3# for quad, hip flex, adduction and abduction to increase mm strength and improve patients ability to stand and strengthen right recent BKA to prepare for prosthesis."</p>	F 318			

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F 318	<p>Continued From page 98</p> <p>On 10/5/16 at 2:17 pm, a TEN documented Resident #5 completed bilateral lower extremity seated therapeutic exercise on the edge of bed with manual resistance 2x15 reps to increase strength in improve functional mobility.</p> <p>On 10/17/16 at 6:37 pm, a Social Service note completed by LSW, documented Resident #5 stated he had not had skilled therapies. The note indicated the Therapy Director communicated to the LSW that Resident #5 was utilizing skilled therapy 8 times a month until he received his device.</p> <p>A Clinic Orthotic note, dated 10/18/16, documented a knee contraction in extension. It stated, "ROM is 0 degree extended position and flexes to 35 degrees." Resident #5 "needs to work on single leg strength to improve ability to walk once prosthesis is manageable. I am concerned about the limited ROM in knee flexion. This will hinder the patients ability to walk efficiently if not resolved and worked on."</p> <p>On 10/18/16 at 4:46 pm, a PT note documented, "Encourage resident to focus on right knee flexion in preperation of prosthesis."</p> <p>On 10/19/16 at 4:50 pm, a PT note documented "Active and active assisted right knee flexion sitting on edge of bed. Therapeutic exercise to improve joint range using static stretching for the right lower extremity targeting knee flexion and knee extension...to increase ROM and to enchance functional mobility."</p> <p>On 10/20/16 at 10:00 am, Resident #5 was sitting in his wheelchair. He stated he went to his</p>	F 318			

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F 318	Continued From page 99 appointment for prosthesis fitting and was told the ROM in his right knee was not good. "They gave me some exercises to do."  5. Resident #12 was re-admitted to facility on 3/12/10, and re-admitted again on 9/16/16, following hospitalization for pneumonia. Her diagnoses included history of CVA with right hemiparesis (weakness to right side) and aphasia (speech impairment).  A critical care admission note documented Resident #12 did not move her right upper extremity and her right upper extremity was flexed at the elbow and at the wrist. It documented Resident #12's hand was closed. The note stated she was unable to move the right upper extremity; likely secondary to contractures.  Resident #12 did not have a plan of care in place reflective of the current contracture of the right upper extremity. Her Care Plan for prevention of skin breakdown did not include the right hand which was contracted in a closed fist position. The Care Plan was not revised or updated to reflect care of the contracture.  Resident #12 record was reviewed and did not include documentation, or physician orders, addressing contractures or treatment for contractures of the right upper extremity. The DNS stated Quality of Life rounds were completed weekly with therapy staff to identify residents that may need therapy or a Restorative Nursing program. LN #4 and the DNS stated Resident #12 had not received therapy or Restorative Nursing for her right upper extremity.	F 318			
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328		12/14/16	

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F 328 SS=D	<p>Continued From page 100 NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure O2 was administered according to physician orders for 1 of 2 sample residents (#3) reviewed for specialty care. Failure to provide O2 continuously as ordered placed the resident at risk of respiratory complications. Findings include:</p> <p>Resident #3 was admitted to the facility on 9/28/16, with multiple diagnoses including vertebral compression fracture, acute pain, atrial fibrillation and MI.</p> <p>Resident #3's 10/5/16 admission MDS assessment documented intact cognition and O2 use while in the facility.</p> <p>One care plan focus area was "exhibits or is at risk for complications" initiated 9/29/16, and revised 10/11/16, and one intervention was, "O2</p>	F 328	<p>328 Special Needs</p> <ol style="list-style-type: none"> <li>1) Resident #3s oxygen was noted to be on and at prescribed liter flow rate by UM on or before 11/4/16. Resident assessed for any adverse effects related to oxygen not observed by surveyor without noted as being in place and no effects noted.</li> <li>2) Residents with orders for oxygen were assessed on or before by members of the IDT to ensure proper liter flow and administration of oxygen.</li> <li>3) Staff were reeducated by CNE on or before 11/30/16 regarding monitoring for proper administration of oxygen to residents with orders.</li> <li>4) Beginning the week of 11/28/16 CNE</li> </ol>		

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F 328	Continued From page 101 as ordered via nasal cannula."  Resident #3's Transfer Orders/Instructions, dated 9/27/16, included O2 at 1 LPM by NC. The resident's facility Medication Review Report of orders "Current On or After Date: 10/1/2016" included O2 at 1 LPM via NC "continuously."  Resident #3 was observed without a NC in place and breathing room air on 10/17/16 at 10:50 am, 11:00 am, 1:51 pm to 1:57 pm, 2:15 pm, 3:00 pm and 3:45 pm; and on 10/18/16 at 8:25 am, 10:25 am, 11:15 am, and 12:45 pm.  On 10/18/16 at 2:25 pm, Resident #3 was observed in bed with a NC in place. The NC was connected to an O2 concentrator set at 1 LPM. At 2:30 pm, RN #5 and RN #6 were asked when Resident #3's O2 was applied. Both of the RNs denied applying the O2 and said the resident had the O2 on "all along."  On 10/18/16 at 3:45 pm, Resident #3 was observed in bed with the NC in place at 1 LPM. When asked about the O2 NC, she said "someone" put it on her earlier that afternoon but she did not know why. Resident #3 recognized the surveyor and said she remembered talking to the surveyor that morning and the day before.	F 328	or designee will conduct an audit of 5 residents per week for four weeks and 2 residents per week for 2 months to ensure residents are receiving oxygen in accordance with their physician order.. Beginning in December 2016 the results of these audits will be presented by the CNE during the QAPI committee meeting monthly for a minimum of 3 months or until compliance is sustained, with revision to the performance improvement plan as necessary for continued improvement.		
F 329 SS=D	483.25(I) 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	F 329		12/14/16	

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F 329	<p>Continued From page 102</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure psychotropic medications were provided with adequate monitoring. This was true for 1 of 3 residents (#6) sampled for psychotropic medication use. The deficient practice had the potential for more than minimal harm should medications not have their desired effect, lead to adverse consequences, or if residents received excessive dosages over prolonged periods of time. Findings include:</p> <p>Resident #6 was re-admitted to the facility on 10/5/12 with multiple diagnoses, including paranoid schizophrenia.</p>	F 329	<p>329 Unnecessary Medications</p> <p>1) Resident # 6 was assessed and interviewed for current behaviors related to psychological diagnosis by LSW on or before 11/4/16. No changes needed to current behavior flow sheet or medications at this time Patient #6 was seen by his psychiatrist on 10/25/16 who recommended no medication changes at this time. Medications were reviewed for appropriateness by a pharmacist on or before 11/30/16.</p> <p>2) Residents on psychotropic medications were assessed by RN on or</p>		

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F 329	<p>Continued From page 103</p> <p>Resident #6's October 2016 Physician Orders' review, documented he received Risperdal 3 mg at bedtime for paranoid Schizophrenia, beginning 8/12/16. (Resident #6 had been on Risperdal previously, since admit, at varying doses.)</p> <p>The 8/20/16 Quarterly MDS assessment documented Resident #6 exhibited no behaviors or cognitive or decision making impairments, and presented with no signs of depression. The MDS documented he had delusions, however no hallucinations or psychosis-related behaviors. Resident #6's previous MDS assessments from December 2015 through May 2016 documented no delusions, hallucinations or psychosis-related behaviors.</p> <p>Resident #6's Impaired Cognitive Function Care Plan, revised 4/3/16, documented he was at risk for a cognitive decline related to hallucinations and delusions. The care plan did not include his use of the psychotropic medication or resident-specific behaviors staff were to monitor for.</p> <p>Resident #6's Delirium Care Plan, dated 9/23/15, documented he was at risk for symptoms of delirium. Interventions included staff was to attempt to refocus Resident #6 to something positive when he was delusional.</p> <p>Resident #6's Psychosocial Well-being Care Plan, revised 4/3/16, did not include use of the psychotropic medication or resident-specific behaviors staff were to monitor for. Resident #6's interventions were updated 8/5/16, to include attendance at the Sol-Oasis Program Groups and staff were instructed to encourage him to</p>	F 329	<p>before 11/30/16 for proper diagnosis for the medication and for negative side effects related to the medications; with concerns addressed with each resident's personal medical practitioner.</p> <p>3) Center direct care staff were educated by the CNE or designee on or before 12/12/16 about the process for addressing and documenting concerns related to a resident's medication regime and/or any related conditions.</p> <p>4) Beginning the week of 11/28/16 CNE or designee will conduct an audit of 5 residents per week for four weeks and 2 residents per week for 2 months to ensure are receiving proper medications according to their diagnoses and related conditions.</p> <p>Beginning in December 2016 the results of these audits will be presented by the CNE during the QAPI committee meeting monthly for a minimum of 3 months or until compliance is sustained, with revision to the performance improvement plan as necessary for continued improvement.</p>		

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F 329	<p>Continued From page 104</p> <p>participate in social based groups where he could receive positive feedback for his efforts.</p> <p>Resident #6's Risk of Complications related to Psychotropic Use Care Plan, revised 10/3/16, documented he would have the smallest effective dose without side effects. Interventions included:</p> <ul style="list-style-type: none"> <li>* Monitor for side effects and consult MD PRN.</li> <li>* Staff was to complete the behavior monitoring flow sheet.</li> </ul> <p>The care plan did not include what the side effects of the medication were. In addition, the care plan did not include the specific psychotropic medication he used or resident-specific behaviors staff were to monitor for.</p> <p>A 3/18/16, Psychiatrist note documented Resident #6 had no evidence of psychotic symptoms. The note documented he was stable on a low dose of Risperdal.</p> <p>A 4/22/16, Psychiatrist note documented Resident #6 had no evidence of psychotic symptoms.</p> <p>A 6/10/16, Psychiatrist note documented Resident #6 had no evidence of psychotic symptoms. The note documented a GDR was recommended and the facility was to continue psychosocial and environmental interventions.</p> <p>A 7/15/16, Psychiatrist note documented Resident #6 had some delusional thinking and denied hallucinations. The note documented the nursing staff reported to the physician that</p>	F 329			

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F 329	<p>Continued From page 105</p> <p>Resident #6 had increased irritability and poor decision making and had experienced delusions about surgical incisions in his buttock area that prevented him from taking showers. Non-pharmalogical interventions attempted were not documented. The note documented Resident #6's Risperdal was increased. There were no corresponding nursing notes documenting the delusions or increased irritability and poor decision making in Resident #6's records.</p> <p>A 7/26/16, Social Services' note documented Resident #6 told staff he had received a check and wanted to get the money. Resident #6's record did not document how it was determined the check was a delusion, or negative behavior exhibited by Resident #6 in relation to it.</p> <p>A 7/27/16, Psychiatrist note documented Resident #6 had some delusional thinking. The note documented he experienced anxiety because he was not allowed to live independently. In addition, the note documented his Risperdal was increased.</p> <p>A 8/12/16, Psychiatrist note documented Resident #6 wanted to manage his own affairs and become his own guardian. The note documented Resident #6 had a legal guardian. The note further documented Resident #6 knew he had a short term memory problem that did affect his day-to-day functioning, however he felt that he could still make decisions for himself. The note documented Resident #6 experienced delusions of persecution and somatic in nature, however he denied hallucinations. The note documented Resident #6's Risperdal was again increased. The note did not document how the</p>	F 329			

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F 329	<p>Continued From page 106 delusion affected him negatively.</p> <p>A 8/19/16, Psychiatrist note documented Resident #6 had some delusional thinking but did not describe the delusions or their effect on Resident #6.</p> <p>The March 2016 through August 2016 psychiatrist notes did not documented Resident #6 experienced any hallucinations.</p> <p>Resident #6's Social Services' Psychotherapeutic Meeting Notes, documented as reviewed on 6/10/16, 7/15/16, 7/27/16, and 8/12/16, did not include the type and frequency of delusions or hallucinations he experienced. The negative impact of them on Resident #6 was, also, not documented.</p> <p>A 9/29/16, Resident Assessment Note documented Resident #6 had no changes in behavior symptoms, he experienced hallucinations, and was self-isolating. The note did not describe what the hallucinations were of how they affected him negatively.</p> <p>Resident #6's Nurses' Notes, from 5/3/16 through 10/17/16, did not include documentation of Resident #6's delusions or hallucinations.</p> <p>Resident #6's 6/1/16 - 10/18/16 MAR/TAR Behavior Monitoring records, documented staff were to monitor for behaviors to include self-isolation, hallucinations, and rejection of cares.</p> <p>The 6/1/16 - 10/18/16 MAR/TAR Behavior Monitoring records, documented Resident #6 did</p>	F 329			

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F 329	<p>Continued From page 107</p> <p>not experience episodes of hallucinations, self-isolation, or rejection of cares.</p> <p>The 6/1/16 - 10/18/16 MAR/TAR Behavior Monitoring records did not include a space for staff to monitor for delusions.</p> <p>Resident #6's 6/1/16 - 10/18/16 MAR/TAR records, documented staff was to monitor for adverse reaction and side effects of medications.</p> <p>The 6/1/16 -10/18/16 MAR/TAR records, did not include Resident #6's specific medications to monitor for or side effects listed.</p> <p>On 10/20/16 at 9:50 am, the LSW stated Resident #6 experienced a hallucination of getting a check and he wanted his money. This happened back in July of 2016. She stated he said he had seen the check and did not know what happened to it. She stated he continued to perseverate on the check. Resident #6's guardian was asked about the check and stated he did not receive one. The LSW stated his guardian asked for him to be re-evaluated by the psychiatrist because he was distracting her with continually asking about seeing his financial information and wanting be become his own guardian. The LSW stated she could not tell the difference between his delusions or hallucinations. She stated the facility monitored for all type of delusions and hallucinations to include dysphoric [unhappy] in nature or happy in nature. She stated it was up to the psychiatrist to determine what type of delusions required medications or not. She stated his psychiatrist wanted to see Resident #6's psychosocial health stabilize and his delusions better controlled. The</p>	F 329			

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F 329	Continued From page 108 LSW stated she could not find documentation in Resident #6's record that his delusions were being monitored.	F 329			
F 363 SS=E	Resident #6 was not effectively monitored for hallucinations and delusions to measure the efficacy and continued use of the antipsychotic medication, Risperdal. In addition, Resident #6's clinical record did not include instructions for staff to monitor him for, and document, his delusions.  483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, menu review, and staff interview and resident interview, it was determined the facility failed to ensure recipes were followed for 12 of 13 (#1-#10, #12, and #13) sampled residents residing in the facility, and all other residents in the facility except those receiving tube feeding. This created the potential for dissatisfaction and weight loss. Findings include:  1. The group interview was held, on 10/19/16 at 11:30 am, with 4 residents in attendance. The four residents expressed concerns with the menu. Issues included inconsistent portion sizes, undercooked foods, cold food, dry and tough	F 363	363 Menus and Nutritional Adequacy  1) Residents were reminded by the administrator on 11/22/16 of the Dietary Council held with the Senior Dietary Manager, or designee, that occurs monthly, with minutes kept, where menu and food service issues are discussed between residents and the department.  A Dietary Council Meeting was held on 11/22/16 where residents communicated with dietary staff regarding menus, food palatability, snacks, and the overall dining experience. Concerns were addressed in	12/14/16	

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F 363	<p>Continued From page 109</p> <p>meats, and menu items not always being provided. Residents' comments included:</p> <ul style="list-style-type: none"> <li>* Two residents reported peanut butter and jelly runs out often or they ended up with two slices of bread with peanut butter and what looked like food coloring smeared on bread.</li> <li>* One resident reported s/he always ordered something like salads or sandwiches which made it hard for the kitchen to mess up. Sometimes the kitchen still messed it up by not providing the salad that was ordered.</li> <li>* One resident complained the serving sizes were not consistent. The resident gave an example of beets and potatoes on the menu, and servings were to be 1/2 cup and what came out on the plate was mostly beets and what looked like 3 tablespoons. of potatoes.</li> </ul> <p>Residents stated there was no food committee with the Dietary department for discussing food concerns but they would like one. They stated they tell the servers and it never seems to get back to the kitchen.</p> <p>2. On 10/19/16 the dinner options for residents were as follows:</p> <ul style="list-style-type: none"> <li>* Oven fried Chicken</li> <li>* O'Brien Potatoes</li> <li>* Sliced Carrots</li> </ul> <p>Alternate:</p> <ul style="list-style-type: none"> <li>* Fish Provencal</li> <li>* O'Brien Potatoes</li> <li>* Chopped Greens</li> <li>* Parsley Garnish</li> </ul> <p>With each meal the following choices were</p>	F 363	<p>accordance with the Dietary Council protocols.</p> <p>Residents <input type="checkbox"/> #1, #10, #12, and #13 were interviewed by the Senior Director of Dining Services regarding their food experience in this facility. Any concerns were addressed on or before 11/30/16.</p> <p>2) Residents were evaluated for nutritional status by center nurse managers and a Registered Dietician on or before 11/30/16. Identified needs were addressed appropriately by the center clinical interdisciplinary team.</p> <p>3) System Changes <input type="checkbox"/> Modified portion size charts were posted to serve-out areas and production books for quick reference by server.</p> <p>Kitchen staff were re-educated and validated for understanding by return demonstration for the appropriate portion sizes for all diet types, for following recipes, and therapeutic texture preparation, in accordance with policies, by the Senior Dietary Manager or designee, on or before 12/12/16.</p> <p>4) Senior Director of Dining Services or designee will continue to hold monthly Dietary Council Meetings. Minutes, including follow-up will be maintained by the Senior Director of Dining Services or designee.</p> <p>Test tray audits will be performed for</p>		

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F 363	<p>Continued From page 110 available.</p> <ul style="list-style-type: none"> <li>* Cornbread</li> <li>* Margarine</li> <li>* Golden Caramel Cake</li> <li>* 2% Milk</li> <li>* Coffee</li> </ul> <p>On 10/19/16 at 2:14 pm, the kitchen staff were preparing the dinner meal. The first observation was the Puree Fish Provencal. The cook stated she was making 5 puree's 2 for one hall, 1 for another hall and 2 extras.</p> <p>The recipe for Fish Provencal included instructions for staff to portion one fish fillet per serving, and ladle 1 oz vegetable sauce over the top.</p> <p>The Puree Fish Provencal recipe instructed staff to prepare the fish per the recipe and remove the needed portions. (For 5 servings of puree food the recipe called for 5 fish fillets.) After the portions were removed, staff were to transfer them into a food processor and blend them until they reached a soft whipped cream consistency.</p> <p>Cook #1 started making the fish puree. She took three fish fillets and placed them in the blender. She then placed 5 ladles full of the vegetable sauce in the blender and proceeded to pour margarine into the blender. There were no measuring utensils used for the margarine. She did not follow the recipe for the amount of sauce or fish for how many servings she was making.</p> <p>On 10/19/16 at 2:20 pm, Cook #1 started preparing the carrots.</p>	F 363	<p>palatability and diet order compliance 5 times per week for 4 weeks beginning the week of 11/28/16 and then 3 times per week for two months. Beginning December 2016, the results of these audits will be presented in the facility QAPI meeting by the Assistant Dietary Manager or designee for three months or until compliance is achieved.</p>		

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F 363	<p>Continued From page 111</p> <p>* The Sliced Carrot recipe called for ingredients of frozen carrots, margarine, garlic, pepper, and salt. The recipe instructed staff to remove the carrots from the steamer and place them into a pan. The recipe instructed staff to melt the margarine, add the seasonings, and pour the seasoning and margarine mixture over the carrots.</p> <p>Cook #1 removed the carrots from the steamer. The margarine, garlic pepper, and salt, were not added to the pan. Cook #1 stated she had already added them.</p> <p>* The Puree Carrots recipe instructed staff to prepare the carrots per the recipe and remove the needed portions. For 5 servings of puree food the recipe called for 2 1/2 cups. After the portions were removed, staff were to transfer them into a food processor and blend them until they reached a soft whipped cream consistency. If the carrots were too thick staff were to add a small amount of low sodium broth or hot water.</p> <p>Cook #1 took a slotted spoon and placed three spoonfuls of carrots into the food processor and proceeded to pour melted margarine into the food processor. When she was asked how much margarine she used she stated, "I can measure it out if you would like." There was no low sodium broth out for her to use as a thinning agent. She continued to add more margarine into the carrots to get it to the smooth consistency. Cook #1 used margarine, instead of a small amount of low sodium broth or hot water, to create a smooth consistency. Additionally, she did not measure the carrots and margarine, as per the recipe.</p>	F 363			

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F 363	<p>Continued From page 112</p> <p>On 10/19/16 at 2:39 pm, Cook #1 started to prepare the puree cornbread.</p> <p>* The pureed cornbread recipe instructed staff to remove needed portions. (The cook stated she was preparing 5 puree.)</p> <p>She followed the recipe for this food item. The cook stated she was making 5 puree's 2 for one hall, 1 for another hall and 2 extras. However the cook used three slices of corn bread instead of 5 like she stated she was preparing.</p> <p>On 10/19/16 at 2:45 pm, Cook #1 started to prepare the chopped greens and the puree greens.</p> <p>* The Chopped Greens recipe called for ingredients of frozen greens, margarine, white pepper, and salt. The recipe instructed staff to remove the greens from the steamer and place them into a pan. It instructed further for staff to melt the margarine, add the seasonings, and pour the seasoning and margarine mixture over the greens and stir gently.</p> <p>Cook #1 opened the bags of greens and placed them into a pan. When she was asked how many servings she was making she stated she did not know, and this vegetable was the alternate vegetable. When asked, Cook #1 indicated she did not know how much pepper and salt was to be added if she did not know how many servings she was preparing. Three bags of greens were opened into three different pans. Cook #1 sprinkled the pepper onto the surface of the greens and used a 1/2 tsp to measure the salt. Cook #1 did not add the margarine to the three</p>	F 363			

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F 363	<p>Continued From page 113 pans of greens.</p> <p>* The Puree Greens recipe instructed staff to prepare the greens per the recipe and remove the needed portions. For 5 servings of puree food the recipe called for 2 1/2 cups. After the portions were removed, staff were to transfer them into a food processor and blend them until they reached a soft whipped cream consistency. If the greens were too thick staff was to add a small amount of low sodium broth or hot water.</p> <p>Cook #1 used a slotted spoon and placed two spoonfuls of greens into the food processor and poured melted margarine into the food processor. The greens were not measured to ensure 2 1/2 cups of greens were used, as stated in the recipe. Cook #1 was asked if she was going to add the pepper and salt and she stated, "oh yeah." There was no low sodium broth out for her to use as a thinning agent. Cook #1 continued to add more margarine, instead of low sodium broth or hot water, into the greens to create a smooth consistency.</p> <p>Cook #1 stated she was done making all the puree food. She was asked if she was going to make the potatoes and stated she had forgotten about them but would prepare them then.</p> <p>On 10/19/16 at 3:22 pm, Cook #1 started to prepare the puree potatoes.</p> <p>* The Puree O'Brien Potatoes recipe instructed staff to prepare the potatoes per the recipe and remove the needed portions. For 5 servings of puree food the recipe called for 3 &amp; 3/4 cups of potatoes. After the portions were removed, staff</p>	F 363			

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F 363	<p>Continued From page 114</p> <p>were to transfer them into a food processor and blend them until they reached a soft whipped cream consistency. If the potatoes were too thick staff was to add a small amount of low sodium broth or hot water.</p> <p>Cook #1 used a spatula put the potatoes into the food processor. She used 3 spatulas full and then proceeded to pour melted margarine into the food processor. There was no low sodium broth out for her to use as a thinning agent. She continued to add more margarine into the potatoes to get it to a soft whipped cream consistency. Cook #1 did not measure out 3 &amp; 3/4 cups of potatoes, as per the recipe. She did not follow the recipe of the potatoes by not measuring out the potatoes. Additionally, low sodium broth or hot water was not used to create a soft whipped cream consistency.</p> <p>On 10/21/16 at 8:25 am, the Dietary Manager and the Executive Chef stated staff should be following recipes to get the same product each time. They stated that was reason for the use of standardized recipes.</p> <p>3. On 10/19/16 at 5:08 pm, the first meal tray was dished up. The cook had one sized scoop per food item. Residents meals were all served using the same scoop, including those who received small portions and large portions. The scoops were not observed to be filled consistently with regular portion sizes. Two regular trays were prepared back to back. One tray had a heaping scoop of greens while the other tray had a partially filled scoop. The plate with the heaping greens was too full to accommodate a full serving of potatoes, so the potato scoop was partially</p>	F 363			

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F 363	<p>Continued From page 115</p> <p>filled with just enough potatoes to fit in the space left on the plate.</p> <p>On 10/21/16 at 8:25 am, the Dietary Manager and the Executive Chef stated there was a portion size chart on the tray line and staff should be utilizing it. The Modified Portion Size Chart included "menu", "small portion" and "large portion" sizes. An example included:</p> <ul style="list-style-type: none"> <li>* The "menu" sized portion for starches was 1/2 cup.</li> <li>* The "small" sized portion for starches was 1/3 cup.</li> <li>* The "large" sized portion for starches was 3/4 cup.</li> </ul> <p>4. On 10/19/16 at 6:00 pm, a puree test tray was tested. The meal consisted of:</p> <ul style="list-style-type: none"> <li>* Puree Chicken, with a temperature of 122.9 degrees. The chicken was dry and appeared crumbly.</li> <li>* Puree Fish Provencal, with a temperature of 123.6 degrees. The fish had lumps throughout and was not whipped cream consistency.</li> <li>* Puree Carrots, with a temperature of 125.9 degrees. The carrots tasted good, but were luke warm.</li> <li>* Puree Greens, with a temperature of 125 degrees. The greens were stringy and luke warm.</li> </ul> <p>On 10/19/16 at 6:00 pm, the Dietary Manager tasted the food and saw the clumps and stringiness of the food items listed above. There were no puree potatoes, cornbread, or dessert to try. There was not enough left over after the food</p>	F 363			

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F 363	Continued From page 116 was served. When the puree tray was dished up, full scoops of the chicken, and fish were not provided because there was not enough left.	F 363			
F 364 SS=E	Residents #1-#10, #12, and #13, consumed food prepared in the kitchen. The facility failed to ensure menus and recipes were followed by staff. Failure to follow the recipes changed the nutrient contents of the menus. In addition, the facility failed to ensure portion sizes were consistently served per their guidelines. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, menu review and staff and resident interview, the facility failed to ensure meals were served that were flavorful and appealing for 3 of 13 (#7, #9 and #10) sampled residents residing in the facility, 4 of 4 residents in the group interview, and the three residents who received pureed diets. Foods were not sufficiently hot, recipes were not followed resulting in foods being too salty or bland, pureed foods were not prepared in a manner enhancing flavor. This deficient practice created the potential for residents to experience unplanned weight loss, diminished nutritional health, and decreased sense of control of their environment. Findings included:	F 364	364 Food Palatability, Preparation, & Temperature  1) Dietary staff were re-educated by the Senior Director of Dining Services, on or before 12/12/16, on methods to improve temperature retention in modified texture food items. Residents #7 no longer resides in the facility. Residents 9 & 10 were interviewed by the Senior Director of Dining Services on or before 12/12/16 regarding food palatability; with individual concerns addressed. Follow-up discussions were had with these	12/14/16	

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F 364	Continued From page 117  1. A Resident Group Interview was held on 10/19/16 at 11:30 am with 4 residents in attendance. Four residents expressed concerns with the menu. Issues included inconsistent portion sizes; undercooked foods; cold food; dry and tough meats; and menu items not always being provided. Residents' comments included:  * Three residents reported the lettuce leaves for salads were too large to eat and needed chopped. * Four residents reported meats like pork were so tough they had to cut it with a hacksaw. In addition, it was dry and needed some sort of sauce to make it palatable. Sometimes sauces would be on the menu and what was served was a dry piece of chicken or pork and no sauce. * One resident stated ground meats were pulverized beyond recognition. * Four residents complained that the food did not have good flavor and lacked spices. * One resident complained the serving sizes were not consistent. They gave an example of beets and potatoes on the menu, and servings were to be 1/2 cup and what came out on the plate was mostly beets and what looked like 3 tablespoons of potatoes. * Two residents stated baked potatoes or whole potatoes were usually raw and could not be cut easily. * Three residents reported breakfast was cold in morning and it all depended on how many staff members were helping serve the food.  Residents stated there was no food committee with the Dietary department for discussing food concerns but they would like one. They stated	F 364	residents to ensure ongoing satisfaction. These are documented.  2) Resident satisfaction surveys, for both short-stay and long stay residents were evaluated on or before 12/12/16 by the Center Administrator to identify other areas concerns. Residents were interviewed by facility managers, on or before 12/12/16 at the time of their meals to assess whether resident needs and desires related to food service and palatability are being met. Identified concerns have been addressed. Failure to meet the standard in this area has the potential to affect all residents except those who are NPO.  3) Modified texture foods are now kept in greater quantities on the steam table prior to service in order to improve heat retention; and food temperatures are taken prior to service to the hall.  Residents were reminded of the monthly Dietary Council by the administrator, on or before 11/30/16 as a means to voice their opinions as a group; as well as about the grievance process for individual concerns. Residents were also reminded of the opportunity to ask for a meal replacement or alternate at the time of service if they are dissatisfied with the product.  Dietary staff received education, on or before 11/30/16 by the Senior Director of Dining Services or designee, regarding		

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F 364	<p>Continued From page 118</p> <p>they tell the servers and it never seems to get back to the kitchen.</p> <p>2. On 10/19/16 the dinner options for residents were as follows:</p> <ul style="list-style-type: none"> <li>* Oven fried Chicken</li> <li>* O'Brien Potatoes</li> <li>* Sliced Carrots</li> </ul> <p>Alternate</p> <ul style="list-style-type: none"> <li>* Fish Provencal</li> <li>* O'Brien Potatoes</li> <li>* Chopped Greens</li> <li>* Parsley Garnish</li> </ul> <p>With each meal the following choices were available.</p> <ul style="list-style-type: none"> <li>* Cornbread</li> <li>* Margarine</li> <li>* Golden Caramel Cake</li> <li>* 2% Milk</li> <li>* Coffee</li> </ul> <p>On 10/19/16 at 2:14 pm, the kitchen staff was preparing the dinner meal. The first observation was the Puree Fish Provencal.</p> <p>* The recipe for Fish Provencal included instructions for staff to portion one fish fillet per serving, and ladle 1oz vegetable sauce over the top.</p> <p>*The Puree Fish Provencal recipe instructed staff to prepare the fish per the recipe and remove the needed portions. Once the portions were removed, staff was to transfer them into a food processor and blend them until they reached a soft whipped cream consistency.</p>	F 364	<p>the proper way to process therapeutic diets, follow recipes, and maintain food temperatures.</p> <p>4) Test tray audits will be performed for palatability and diet order compliance 5 times per week for 4 weeks beginning the week of 11/28/16 and then 3 times per week for two months. Resident follow-up will occur in the monthly Dietary Council meeting.</p> <p>Long-stay and short-stay resident satisfaction surveys will continue to be administered and monitored to allow for anonymous voicing of opinions and concerns; including those related to food service and palatability.</p> <p>Beginning the week of 12/12/16 random residents will be surveyed at 5 meals per week to solicit their opinions regarding food service, flavor, texture, and temperature.</p> <p>The results of the above mentioned audits will be reviewed by Dining Services Management with the facility administrator weekly to ensure that the concerns are tracked and addressed in a timely and appropriate manner.</p> <p>Beginning December 2016, the results of these audits will be presented in the facility QAPI meeting by the Senior Director of Dining Services or designee for a minimum of three months or until compliance is achieved and sustained as</p>		

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F 364	<p>Continued From page 119</p> <p>The Cook #1 started making the fish puree. She took three fish fillets and placed them in the blender. She then placed 5 ladles full of the vegetable sauce in the blender and proceeded to pour margarine into the blender. There were no measuring utensils used for the margarine. She took the fish out without tasting it and placed it into a serving dish, covered it with foil, wrote on the top, and placed it into a warmer.</p> <p>On 10/19/16 at 2:20 pm, Cook #1 started preparing the carrots.</p> <p>* The Sliced Carrot recipe called for ingredients of frozen carrots, margarine, garlic, pepper, and salt. The recipe instructed staff to remove the carrots from the steamer and place them into a pan. It instructed further for staff to melt the margarine, and adding the seasonings to this and pour the seasoning and margarine mixture over the carrots.</p> <p>Cook #1 removed the carrots from the steamer and the margarine, garlic pepper and salt was not added to the pan. Cook #1 stated she added them already.</p> <p>* The Puree Carrots recipe instructed staff to prepare the carrots per the recipe and remove the needed portions. After the portions were removed, staff was to transfer them into a food processor and blend them until they reached a soft whipped cream consistency. If the carrots were too thick staff was to add a small amount of low sodium broth or hot water.</p> <p>Cook #1 took a slotted spoon and placed three</p>	F 364	evidenced by the outcomes of the anonymous, third party administered, resident and family satisfaction surveys.		

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F 364	<p>Continued From page 120</p> <p>spoonfuls of carrots into the food processor and proceeded to pour melted margarine into the food processor. When she was asked how much margarine she used she stated, "I can measure it out if you would like." There was no low sodium broth out for her to use as a thinning agent. She continued to add more margarine into the carrots to get it to the smooth consistency.</p> <p>Cook #1 took the carrots out without tasting them and placed them into a serving dish, covered it with foil, wrote on the top, and placed it into warmers. The cook stated she was making 5 purees, 2 for one hall, 1 for another hall, and 2 extras. She did not follow the recipe of the carrots by not measuring the carrots and margarine and by not following the process to puree foods.</p> <p>On 10/19/16 at 2:45 pm, Cook #1 started to prepare the chopped greens and the puree greens.</p> <p>* The Chopped Greens recipe called for ingredients of frozen greens, margarine, white pepper, and salt. The recipe instructed staff to remove the greens from the steamer and place them into a pan. It instructed further for staff to melt the margarine, add the seasonings, and pour the seasoning and margarine mixture over the greens and stir gently.</p> <p>Cook #1 opened the bags of greens and placed them into a pan. When she was asked how many servings she was making she stated she did not know, and this vegetable was the alternate vegetable. She was asked how much pepper and salt she was to add if she did not know how</p>	F 364			

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F 364	<p>Continued From page 121</p> <p>many servings she was making, and indicated she did not know. Three bags of greens were opened into three different pans. Cook #1 sprinkled the pepper onto the surface of the greens and used one 1/2 tsp of salt per pan. Cook #1 did not add the margarine to the three pans of greens or mix in the pepper and salt. The salt and pepper were sitting on top when she covered the pans.</p> <p>* The Puree Greens recipe instructed staff to prepare the greens per the recipe and remove the needed portions. After the portions were removed, staff was to transfer them into a food processor and blend them until they reached a soft whipped cream consistency. If the greens were too thick staff was to add a small amount of low sodium broth or hot water.</p> <p>Cook #1 used a slotted spoon and placed two spoonfuls of greens into the food processor and proceeded to pour melted margarine into the food processor. She was asked if she was going to add the pepper and salt and she stated, "oh yeah." There was no low sodium broth out for her to use as a thinning agent. She continued to add more margarine into the greens to get it to the smooth consistency.</p> <p>Cook #1 stated she was done making all the puree food. She was asked if she was going to make the potatoes and stated she had forgotten about them but would prepare them then. She did not follow the recipe of the greens by not measuring the greens, forgetting the margarine, and by not following the process to puree foods with adding low sodium broth or hot water.</p>	F 364			

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F 364	<p>Continued From page 122</p> <p>On 10/21/16 at 8:25 am, the Dietary Manager and the Executive Chef stated the staff should be following recipes to get the same product all the time. They said they had standardized recipes for this reason.</p> <p>3. On 10/19/16 at 5:35 pm, a regular textured food tray was tested. The meal consisted of:</p> <ul style="list-style-type: none"> <li>* Oven Fried Chicken, with a temperature of 134 degrees. This tasted good.</li> <li>* Fish Provencal, with a temp of 133 degrees. This tasted good.</li> <li>* Carrots, with a temperature of 135.4 degrees. This tasted good.</li> <li>* Greens, with a temperature of 138 degrees. This tasted good.</li> <li>* Potatoes O'Brien, with a temperature of 138 degrees. The potatoes were salty in flavor and felt barely warm. They looked crusty on the outside, tasted soggy on the inside.</li> </ul> <p>On 10/19/16 at 6:00 pm, a puree test tray was tested. The meal consisted of:</p> <ul style="list-style-type: none"> <li>* Puree Chicken, with a temperature of 122.9 degrees. The chicken was dry and crumbly looking.</li> <li>* Puree Fish Provencal, with a temperature of 123.6 degrees. The fish had lumps throughout and was not whipped cream consistency.</li> <li>* Puree Carrots, with a temperature of 125.9 degrees. The carrots tasted good, but were slightly warm.</li> <li>* Puree Greens, with a temperature of 125 degrees. The greens were stringy and slightly warm.</li> </ul>	F 364			

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F 364	Continued From page 123 On 10/19/16 at 6:00 pm, the Dietary Manager tasted the food and saw the clumps and stringiness of the food items listed above. There were no puree potatoes, cornbread, or dessert to try. There was not enough left over after the food was served. When the puree tray was being dished up, full scoops of the chicken, and fish were not provided because there was not enough left.  On 10/20/16 at 8:30 am, a regular breakfast tray was tested. The meal consisted of:  * Sausage, with a temperature of 141.4 degrees. This tasted good. * Scrambled eggs, with a temperature of 135 degrees. The eggs were greasy/buttery in flavor and did not taste good. The eggs looked dried out with crusty browned edges and were two shades of yellow; a dark and light yellow. * Bacon, with a temperature of 121.7 degrees. This tasted good.  On 10/20/16 at 8:30 am, the Dietary manager tasted the food and saw the eggs.  The facility failed to ensure the food served to residents was palatable and looked good. In addition, they failed to ensure the food remained hot for residents to enjoy a hot meal.	F 364			
F 371 SS=E	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	F 371		12/14/16	

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F 371	<p>Continued From page 124 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This was true for 12 of 13 (#1-#10, #12, #13) sampled residents residing in the facility, as well as, all other residents eating food prepared in the facility's kitchen. This had the potential for harm if residents contracted foodborne illnesses. Findings include:</p> <p>Residents #1-#10, #12, and #13 ate food prepared in the facility's kitchen.</p> <p>The facility's Food and Nutrition Services Hand Washing P&amp;P, dated 3/16/15, documented staff should wash their hands frequently. Hand washing was to be performed at these times to include:</p> <ul style="list-style-type: none"> <li>* Staff was to wash hands after handling food.</li> <li>* Staff was to wash hands between working with raw foods to cooked foods.</li> <li>* Staff was to wash hands after contacting any soiled utensils.</li> <li>* Staff was to wash hands before touching any clean utensils.</li> <li>* Staff was to wash hands when moving from one task to another.</li> </ul>	F 371	<p>F371 Food Storage/ Procurement/ and Sanitation</p> <ol style="list-style-type: none"> <li>1) Residents #1, #10, #12, and #13 were evaluated by a RN for signs and symptoms of foodborne illnesses. None were identified.</li> <li>2) Other residents were monitored by the Infection Preventionist RN for signs and symptoms of food borne illness on or before 11/30/16. None were noted.</li> <li>3) On or before 12/12/16 Dietary staff were reeducated on the facility's Food and Nutrition Services Hand Washing P&amp;P by the Senior Director of Dining Services or designee, with a return demonstration of proper hand washing techniques performed. Additionally Dietary staff were educated regarding proper dishware and utensil washing, as well as clean and dirty areas of the kitchen.</li> <li>4) Sanitation audits will be performed for proper food handling protocol and hand washing compliance 5 times per week for 4 weeks beginning the week of 11/28/16 and then 3 times per week for two</li> </ol>		

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F 371	<p>Continued From page 125</p> <p>On 10/19/16 at 2:14 pm, the kitchen staff were preparing the dinner meal. Cook #1 made a fish puree. After she completed it, Cook #1 took the food processor into the dish room, rinsed it out with water, and brought it back out and placed it onto the base. When she left the dish room she did not wash her hands or change her apron.</p> <p>On 10/19/16 at 2:20 pm, Cook #1 made a carrot puree. After she completed it, Cook #1 took the food processor into the dish room, rinsed it out with water, and brought it back out and placed it onto the base. She did not wash her hands after leaving the dish room.</p> <p>On 10/19/16 at 2:39 pm, Cook #1 started to prepare the puree cornbread. She took the food processor over to the dirty dish area and rinsed it out with water. She stopped to wash her hands and then placed the food processor back onto the base.</p> <p>On 10/19/16 at 2:44 pm, Cook #1 picked up a container of foil that fell onto the floor near the food preparation area. She placed the foil onto the food preparation surface and did not wash her hands or get new foil.</p> <p>On 10/19/16 at 2:45 pm, Cook #1 started to prepare the chopped greens and the puree greens. Cook #1 opened the bags of greens and placed them into a pan. She opened a trash can lid next to her with her hand to throw the greens bag away. After she completed making the greens puree, she took the greens out; tasted them; threw the tasting spoon away by opening the trash can lid next to her with her hand. Using the same hand that touched the trash can lid,</p>	F 371	<p>months.</p> <p>Beginning December 2016, the results of these audits will be presented in the facility QAPI meeting by the Assistant Dietary Manager or designee for three months or until compliance is achieved.</p>		

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F 371	<p>Continued From page 126</p> <p>Cook #1 reached into the food processor to remove the blade and placed the greens into a serving dish; covered them with foil; and placed them into a warmers. Cook #1 did not wash her hands. Cook #1 took the food processor into the dish room and handed it to the dish person to run through the sanitizer. She did not wash her hands after leaving the dish room.</p> <p>On 10/19/16 at 2:52 pm, Cook #1 was in the process of preparing Potatoes O'Brien and needed a new dish that was not in her area. She walked into the clean dish area without washing her hands and grabbed a dish. In addition, she was seen touching the trash can lid twice with her hand and not washing her hands after touching the lid, then continuing with food preparation.</p> <p>On 10/19/16 at 5:33 pm, Cook #1 left tray line to get something in the back of the kitchen. She went to the freezer door opened it and returned with an ice-cream container. She did not wash her hands before returning to the tray line.</p> <p>Cook #1 was not wearing gloves throughout the above observations.</p> <p>On 10/21/16 at 8:20 am, the Dietary Manager and the Executive Chef indicated the cook did not follow appropriate handwashing and dishwashing processes. They stated Cook #1 should have sanitized the food processor between different pureed foods to prevent cross contamination. They stated no one in the facility had an allergy to fish but could see a problem if someone did.</p>	F 371			
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		12/14/16	

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F 431 SS=D	<p>Continued From page 127 LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 431			

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F 431	<p>Continued From page 128</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure pharmacy prescription labels on medications reflected the current physicians' orders. This was true for 1 of 14 residents (#17) observed during medication pass. The failure created the potential for medication errors and adverse reactions if the medications were not administered as ordered. Findings include:</p> <p>On 10/20/16 at 7:45 am, LPN #1 was observed as she poured 4 medications, including Lantus insulin, Plavix, and metoprolol tartrate, for Resident #17.</p> <p>The pharmacy label on the Lantus, dispensed 9/25/16, documented, "Inject 10 units subcutaneously every 12 hours..."</p> <p>The pharmacy label on the Plavix, dispensed 9/23/16, documented, "Give 1 tab per feeding tube every day..."</p> <p>The pharmacy label on the metoprolol tartrate, dispensed 9/26/16, documented, "Give 1.5 tabs...per feeding tube twice daily..."</p> <p>LPN #1 drew up 14 units of Lantus in an insulin syringe and placed the syringe on the medication cart. LPN #1 then crushed the 2 1/2 medication tablets together, put the crushed medications in apple sauce, then administered the medications to Resident #17 by mouth. LPN #1 then took Resident #17 into the charting room to administer the insulin. Before the LPN injected the Lantus insulin, she asked about the dosage and was informed the pharmacy label documented 10 units, not 14 units. LPN #1 said the label was</p>	F 431	<p>431 Labeling and Storage of Drugs and Biologicals</p> <p>1) Resident #17's medication cards had sticker placed to refer to chart indicating route change by CNE on or before 10/21/16.</p> <p>2) Resident medication cards were reviewed by CNE or designee on or before 11/30/16 to ensure that orders matched pharmacy labels. Stickers were placed on cards to review chart as indicated through review.</p> <p>3) Physician orders will be reviewed during morning clinical meeting to validate accuracy of orders including but not limited to route. Education was provided by the CNE or designee on or before 12/12/16 regarding the med order process update for LN to change cards with order changes.</p> <p>4) Beginning the week of 11/28/16 for 4 weeks members of the Nurse Management Team will validate 5 resident records with med order changes per week to ensure that the MAR order matches the medication label. This will be followed by 2 resident reviews weekly for two months. Beginning in December, results of these audits will be presented by the CNE or designee during the monthly QAPI meeting. Any negative findings will be addressed through staff education and/or modification to the Performance Improvement Plan as</p>		

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F 431	Continued From page 129 "wrong" and that the order was 14 units, then injected Lantus 14 units into Resident #17.  On 10/20/16 at 7:48 am, when asked about the pharmacy label directions for Plavix and metoprolol administration per feeding tube, LPN #1 said, "That's old." The LPN provided a 9/28/16 physician's order to increase Resident #17's Lantus insulin to 14 units BID and 9/20/16 orders for the Plavix and metoprolol to both be administered by mouth. The DNS joined the interview at that time. The DNS said the Plavix and metoprolol were both dispensed from the pharmacy after the order change and should have documented by mouth rather than per feeding tube. The DNS also said a sticker should have been added to each of the medication pharmacy labels to alert staff that the directions had changed.	F 431	indicated.		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (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.	F 441		12/14/16	

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F 441	<p>Continued From page 130</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and contracted employee record review, it was determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment for all the residents, and to ensure laundry personnel followed policy and procedures related to proper handling of clean and dirty linens. These failed practice created the potential for all residents in the facility to contract infections. Findings include:</p> <p>1. The facility failed to ensure adequate training, supervision, and monitoring of personnel responsible for providing laundry services for the</p>	F 441	<p>441 Infection Control</p> <p>1) Laundry personnel were educated regarding infection control practices related to the handling of linen and the handling of unsanitary items; as well as the identification of the clean and dirty sides of the laundry. This training was provided by the Housekeeping Director and the Center Executive Director on or before 12/12/16 with return demonstration of competence completed.</p> <p>The broken tiles in the West Laundry Room were repaired by the Facility</p>		

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F 441	<p>Continued From page 131 facility. Examples include:</p> <p>A tour of the facility was conducted on 10/21/16 beginning at 8:40 am. The tour was led by the facility Environmental Services Director, Maintenance Director, and the District Manager for the company that provided contracted services of dietary, housekeeping, and laundry.</p> <p>a. In the west wing laundry processing area, LW #1 was observed folding a sheet. She was standing with sheet in outstretched hands, and bent her head down towards her chest to secure the sheet between her chin and chest. LW #1 was not wearing any protective covering over her smock, which was stained in several places. She folded the sheet vertically, then horizontally as she held it against her abdomen, with the clean linen making direct contact with the skin on her neck and under her chin. LW #1 stated, "How else can you fold large items when you are by yourself?"</p> <p>b. In the east wing laundry processing area, a red line on the floor designated the room's dirty and clean areas. There was a large plastic container, similar to a 55 gallon trash container with a plastic bag that was filled with linen items of towels, washcloths, sheets, and a bedspread. The container was uncovered, and in the designated "clean" area between the washer and the dryer, next to a wire basket on wheels that held freshly dried white linens. The Environmental Services Director hovered his hand above the container of assorted linens in the container, and stated it was full of "just laundered items." However, they did not appear to be just laundered. Some items appeared wet,</p>	F 441	<p>Maintenance Director or designee, on or before 11/30/16.</p> <p>Employees received education regarding proper hand hygiene including the proper usage of gloves and when hands should be washed. NPE or designee on or before 12/12/16 with return demonstration of competence completed. Resident #3 was assessed by an RN, on or before 11/30/16, for negative outcomes related to infection control practices.</p> <p>Resident #4 was assessed by an RN, on or before 11/30/16, for negative outcomes related to infection control practices. Resident #4's abrasion is resolved.</p> <p>2) All residents have the potential to be affected by improper infection control techniques.</p> <p>3) Direct Care Staff were educated regarding the current infection control guidelines recognized by the CDC and incorporated into the updated Requirements of Participation for Skilled Nursing Facilities, on or before 12/12/16 by the center NPE or designee.</p> <p>Upon hire and annually Laundry and Housekeeping contract staff will receive facility provided infection control education to ensure understanding and competency.</p> <p>4) Beginning 11/28/16 Infection Control audits will be performed for proper</p>		

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F 441	<p>Continued From page 132</p> <p>some were dry and appeared to have been rolled/shoved into the plastic bag. LW #2 was standing in the laundry anteroom, designated as a "clean" area as she folded linens. LW #2 was questioned if the container held dirty or clean items. She responded with hand gestures and stated "No English." Using basic Spanish and hand movements, LW #2 demonstrated the items were dirty. She rolled the container to the washer. She was wearing the same gloves she had on while folding clean items. LW #2 did not don additional PPE, such as a protective apron, before starting to sort the contents of the container and place items into the washer. She pulled out a bedspread and placed it in a large bin against the wall, put white items in the washer, pulled a pillow out from the pillowcase, and placed the pillow on the lid of a clean linen container. LW #2 was instructed by the Environmental Services Director to stop loading the washer. She walked over to the dryer and pressed several buttons, still wearing the now contaminated gloves. A wire cart on wheels was in front of the dryer, which was identified as "clean and dried laundry," by the District Manager of the contracted company that provided laundry services. LW #2 pulled the cart into the folding area of the laundry area and started folding the items, still wearing the contaminated gloves.</p> <p>2. Training records of LW #1 and LW #2 were requested.</p> <p>On 10/21/16 beginning at 11:50 am, the District Manager for the company that provided contracted laundry services to the facility provided training records and personnel records</p>	F 441	<p>infection control protocol and hand washing compliance 5 times per week for 4 weeks beginning the week of 11/28/16 and then 2 times per week for two months.</p> <p>Beginning December 2016, the results of these audits will be presented in the facility QAPI meeting by the Assistant Dietary Manager or designee for three months or until compliance is achieved. Modifications to this Plan of Correction occur as indicated.</p>		

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F 441	<p>Continued From page 133 for both of the laundry workers.</p> <p>The training records were dated 10/21/16, the day of the Environmental aspect of the survey. The District Manager stated the facility and the contracted company did not have documented evidence of previous training for either laundry worker. He stated he provided training to both individuals that morning after the environmental tour and training records were requested. The District Manager stated he was unable to find documentation of on-site orientation, or annual performance reviews.</p> <p>The facility failed to ensure contracted staff were fully trained, supervised, and monitored to provide sanitary laundry services to their residents.</p> <p>3. In the west wing laundry processing area, in front of the dryer, the linoleum was noted to be cracked and torn. The concrete below the linoleum was also cracked, and an ant was noted entering the cracked area.</p> <p>The facility failed to ensure a clean and sanitary environment for laundry repossessing.</p> <p>2. The facility's Hand Hygiene policy, revised 4/11/16, documented, "2. Decontaminate hands using an alcohol based hand rub OR wash hands with soap and water in the following clinical situations:</p> <ul style="list-style-type: none"> <li>* 2.1 Before any direct contact with patient;</li> <li>* 2.2 Before putting on gloves...2.4 After contact with patient's intact skin...</li> <li>* 2.7 After contact with inanimate objects in the</li> </ul>	F 441			

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F 441	<p>Continued From page 134 immediate vicinity of the patient... * 2.9 After removing gloves."</p> <p>The policy also documented, "3. Follow proper technique for hand hygiene practices. 3.1 To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water...</p> <p>Nursing staff were observed not performing hand hygiene, or improperly performing hand washing, before and/or after direct contact with residents as follows:</p> <p>a. On 10/17/16 at 1:54 pm, CNA #5 was observed as she changed the sheets on Resident #3's bed, assisted her to transfer from the w/c to the bed, assisted her to find a position of comfort, and removed her gloves then left the room. At 1:58 pm, when informed of the observation of no hand hygiene after glove removal following direct contact with the resident, CNA #5 said she would go and wash her hands, which she did.</p> <p>b. On 10/18/16 at 8:47 am, Resident #4 was observed as CNA #7 propelled her in her w/c into her room. The CNA did not perform any type of hand hygiene before she put on exam gloves. At the bedside, the CNA said she needed to get a draw sheet and she left the room while wearing the gloves. CNA #7 was still wearing the gloves when she returned a few moments later. The CNA touched the door handle inside and out with her gloved hands, left then returned to the room wearing the exam gloves. The CNA did not</p>	F 441			

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F 441	Continued From page 135 remove the gloves before she transferred Resident #4 from the w/c to the bed, pulled down the resident's pants and incontinence brief to check for incontinence, pulled the brief and pants up, repositioned her, then lowered the bed. CNA #7 did wash her hands before she left the room. At 8:50 am, CNA #7 said she washes her hands after she takes off gloves, not before she puts on gloves.  c. On 10/20/16 at 10:10 am, RN #4 was observed as she applied soap to her hands then immediately scrubbed her hands under running water prior to providing wound care and dressing change to Resident #4's right hip. After providing the care, RN #4 used the same technique to wash her hands. At 10:10 am, RN #4 said she did not realize she scrubbed her hands under running water.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced	F 514		12/14/16	

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F 514	<p>Continued From page 136</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure the clinical records for 1 of 14 sample residents (#2) was accurate and/or complete. This failure created the potential for inappropriate or unnecessary interventions based on incomplete or inaccurate information, increasing the risk for complications. Findings include:</p> <p>Resident #2 was admitted to the facility on 10/8/13, with diagnoses which included major depression, anxiety, osteoarthritis, dementia, morbid obesity, HTN, CHF, insomnia, and chronic kidney disease.</p> <p>1. Resident #2's record included a form titled PHYSICIAN'S PROGRESS NOTES, undated, and untimed. The handwritten progress note described a dental exam which resulted in the extraction of 2 decayed teeth. The progress note was not clear as to when the procedures were performed, if they occurred at the facility, if a consent for the procedure was obtained, and if instructions for post extraction care was provided to the facility staff.</p> <p>10/21/16 beginning at 10:00 am, the Sol Oasis Unit Manager reviewed the progress note and stated "I have no clue" as to when Resident #2 had the dental procedures. She was unable to find documentation in Resident #2's record to indicate when the procedures were performed. She stated it was her expectation that all residents' medical records would have appropriate documentation such as date, time, and identifying information.</p>	F 514	<p>514 Medical Records</p> <p>1) On or before 11/30/16, for resident #2 the IDT completed a comprehensive review of her care and updated her care plan as appropriate. Behavior monitors were updated to reflect current target behaviors.</p> <p>2) All residents have the potential to be affected if their medical charting is inaccurate or incomplete.</p> <p>3) Resident clinical appointments will be reviewed in the daily clinical meeting and tracked until consultation reports are received to validate that the visit notes are complete and accurate. Behavior monitors will be checked weekly by members of the IDT to ensure accuracy of coding. Education was provided to nursing, by the CNE or designee, on or before 12/12/16, on how to communicate new behaviors and how to follow-up appropriately.</p> <p>4) Beginning the week of 11/28/16 5 resident charts will be audited weekly for 4 weeks and then monthly for two months, to ensure that clinical documentation is received and that behavior monitors are properly coded. Beginning December 2016, the results of these audits will be presented in the facility QAPI meeting by the Center Nurse Executive or designee for three months or</p>		

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F 514	<p>Continued From page 137</p> <p>2. Resident #2's record included inaccurate and conflicting behavioral documentation, as follows:</p> <p>Resident #2's Behavior logs for August, September, and October 2016, were reviewed. The logs included 3 areas of negative behavior to be tracked.</p> <p>a. Behavior Symptom: "RC", which the key identified as Rejection of Care. It stated "Patient rejected evaluation and/or care that is necessary to achieve the patient's goals for health and well-being." There were no entries for the months of August-October 2016.</p> <p>Behavior Symptom: "Banging on overbed table." There were no entries for the months of August-October 2016.</p> <p>Behavior Symptom: "Yelling out repetitive statements." There were 2 documented episodes for the 3 month period, both in August.</p> <p>* On 8/8/16, the log documented Resident #2's number of episodes was documented as "Y3." The key for the behavior log did not include a Y3.</p> <p>- The section to record non-pharmacological interventions, read "C5," which indicated "Listened to patient, attempted to calm." There was no key for the "5" that the clinician documented.</p> <p>- The section titled Result, included an "S." There was no key for the "S" that the clinician documented.</p> <p>* On 8/19/16, the log documented Resident #2's</p>	F 514	until compliance is achieved.		

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F 514	<p>Continued From page 138 number of episodes were documented as "11."</p> <p>- The section to record non-pharmacological interventions, read "G," which indicated Resident #2 was "escorted to room to reduce stimuli." Resident #2 was bed bound. It was unclear how "escorting her back to her room" would apply, given her lack of mobility.</p> <p>- The section titled Result, included an "I," which indicated Resident #2 improved in her behavior.</p> <p>The information on the behavior logs related to Resident #2's two behavioral incidents, did not describe the behaviors, interventions, and Resident #2's response to the interventions.</p> <p>b. TAR's for repositioning Resident #2 every 2 hours, were reviewed for August, September, and October 2016. They showed:</p> <p>* August 10-31, documented Resident #2 allowed staff to turn her 5 of 264 opportunities (based on every 2 hours). The TAR documented her refusal 259 times.</p> <p>* September 1-30, documented Resident #2 allowed staff to turn her 7 of 360 opportunities. The TAR documented her refusal 353 times.</p> <p>* October 1-18, documented Resident #2 allowed staff to turn her 17 of 216 opportunities. The TAR documented her refusal 199 times.</p> <p>Based on the TAR data, Resident #2 rejected staff's efforts to turn her a total of 811 times. Resident #2's behavioral logs, however, documented a total of 2 behaviors any kind</p>	F 514			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>		
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F 514	Continued From page 139 during the same time period.  On 10/21/16 at 10:00 am, the Sol Oasis Unit Manager reviewed Resident #2's record. She stated the logs and TAR's did not match, and stated if Resident #2's other negative behavior occurred only 2 times over 3 months, that behavior was no longer an issue, and her care plans should have been revised.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey conducted at the facility from October 17, 2016 to October 21, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Teresa Kobza, RD/LD Beverly Briggs, RN Nina Sanderson, LSW Susan Costa, RN Edith Cecil, RN</p> <p>ABBREVIATIONS:</p> <p>DNS = Director of Nursing Services ICC = Infection Control Committee IP = Infection Preventionist</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of ICC attendance records, it was determined the facility failed to ensure the Dietary Manager and a representative from the maintenance department and the housekeeping department participated in ICC meetings at least quarterly. The failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:</p>	C 664	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or</p>	12/14/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  11/28/16
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
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C 664	Continued From page 1  On 10/21/16 at 9:40 am, the facility's Infection Control Program was reviewed with the IP. The IP said the ICC met quarterly and that the Medical Director, Pharmacist, Administrator, DNS, and department heads, including herself, participated.  The IP provided ICC attendance records dated 2/9/16, 4/26/16 and 7/19/16. The records documented the following: on 2/9/16, the Dietary Manager, and a representative from maintenance and a representative from housekeeping did not participate in the ICC meeting; on 4/26/16, a housekeeping representative did not participate in the ICC meeting; and on 7/19/16, the Dietary Manager and a housekeeping representative did not participate.	C 664	regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.  C664 Required Infection Control Committee Members  1) On or before 11/30/16 an Infection Control Meeting was held with all required attendees.  On or before 11/30/16 the required participants of the Infection Control Committee, as well as the Infection Preventionist, were educated by the Center Executive Director regarding State Rule IDAPA 16.03.02.150. 02. Infection Control Committee. Which states, an Infection Control Committee shall be appointed by the administrator which shall: (1-1-88) a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. (1-1-88) b. Be responsible for development and implementation of infection control policies and procedures including the designation of a facility employee to monitor practices within the facility. (1-1-88) c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. (1-1-88) d. Review policies and procedures as needed but no less often than annually.	

Bureau of Facility Standards

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C 664	Continued From page 2	C 664	<p>(1-1-88) e. Review the quarterly report of infections prepared by the designated surveillance officer. (1-1-88).</p> <p>2) All residents have the potential to be affected by a failure in the Infection Prevention process.</p> <p>3) On or before 11/30/16 the Regional Manager of Clinical Operations provided education to members of the Infection Control Committee regarding their attendance and participation requirements in the center's Infection Control Committee meetings.</p> <p>4) Beginning in December 2014 and no less frequently than quarterly thereafter the center Infection Preventionist will present a report in the facility's QAPI meeting on the Infection Control Committee meeting; including presenting a roster of attendance.</p>	