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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 01/17/19.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		

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

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. Based on observation, interview, and record review, the facility failed to maintain a sanitary, orderly, and comfortable interior for 5 of 28 rooms, and a shower room, for the residents of the facility. Findings included: - Observations during the initial tour of the facility, on 1/7/19 at 8:17 am, and during the environmental tour with maintenance staff V and administrative staff A, on 1/9/19 at 9:45 am, revealed the following areas/items noted to be in need of repair and /or cleaning: South hall 1.) A shared resident bathroom had an unlabeled hairbrush, with a build-up of gray hair, stored directly on the sink. 2.) A shared resident bathroom had an unlabeled open denture cup, stored directly on the resident's sink. 3.) One resident room had a torn, dirty fall mat,	F 584		

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that had a build-up of black grime in the cracked vinyl.

West hall

1.) Two resident rooms had torn, worn out fall mats, that had a build-up of black grime in the cracked vinyl.

2.) A resident bathroom had cracked linoleum on the floor around the toilet and back of the cove base.

3.) A shared resident bathroom had an unlabeled toothbrush stored on the sink shelf.

4.) A shared resident bathroom had an unlabeled hairbrush, with a build-up of loose hair, and stored on the sink.

East hall

1.) A shower room had a basket on the counter, that identified two different residents, with 3 hairbrushes, that had a build-up of hair intertwined in the brush.

2.) A shower room had a black substance in around the shower stall.

3.) A shower room had a bath sponge directly on the floor.

4.) A resident room had window blinds that were bent and in need of repair.

On 1/7/19 at 10:42 am, direct care staff G reported staff should store clean hairbrushes and toothbrushes in a plastic bag in the resident's

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F 584	Continued From page 3 dresser drawers. On 1/10/19 at 8:40 am, administrative staff E, verified staff should replace fall mats when torn, and staff should have monitored the condition of the resident's fall mats at least quarterly. On 1/10/19 at 8:45 am, direct care staff F, reported he/she was aware of the resident's torn, worn out fall mats. He/she reported the fall mats, to administrative staff, however failed to get the authorization to have all the fall mats replaced. The facility's undated policy for housekeeping, laundry and maintenance, documented the departments must maintain the interior and furnishings in a clean, orderly, and attractive manner. The facility failed to ensure appropriate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for these resident areas.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		

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necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 35 residents with 13 sampled for review. Based on observation, interview, and record review the facility failed to ensure the development and implementation of a base line care plan, within 48 hours of admission, that meet professional standards of quality of care and based on the

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resident's individual needs, for 2 residents (#30 and #134) reviewed.

Findings included:

- Resident #30's, signed physician orders, dated 12/28/18, documented the resident admitted on 11/21/18, with the following diagnoses including; pain, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), major depressive disorder (major mood disorder), and falls.

The baseline care plan, with an open date of 11/21/18, with a plan of care for discharge only, lacked a plan of care for nursing, activities, and dietary considerations. The resident returned to the hospital on 11/26/18. The facility staff failed to complete the residents's baseline care plan for 5 days.

On 1/8/18 at 8:55 AM, the resident's bed was in the low position, with a fall mat beside the bed. The resident was wearing non-skid shoes.(the resident left for a doctors appointment with his/her grandson after interview/observation).

On 1/9/19 at 11:58 AM, direct care staff J stated the resident had a fall mat, a low bed and she should not be left in his/her wheelchair by himself/herself.

On 1/10/19 at 12:50 PM, direct care staff F stated the resident had a fall mat and a low bed the day he/she arrived to the facility. Staff F stated he/she remembered because the nurse asked him/her to.

On 1/9/19 at 1:18 PM, licensed nursing staff W

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stated when he/she admitted a resident to the facility, he/she would go to the electronic care plan tab and open the base line care plan that day. Staff W stated he/she did not usually do the care plan because the SSD (social service designee) and MDS staff would open the care plan and start it.

On 1/8/19 at 4:22 PM, administrative nursing staff H stated the nurse who admitted the resident was to start the care plan. That is the base line care plan, and then SSD staff E would set up the care plan meeting with the families. The care plan meeting should be held within 48 hours of admission. Staff H verified the resident care plan while opened on 11/21/18, lacked a baseline care plan for nursing, dietary, and activities until 12/3/18 after he/she returned from the hospital on 11/29/18.

The facility lacked a policy for the development of baseline care plans. The facility followed the RAI (resident assessment manual).

The facility failed to ensure staff developed and implemented a base line care plan, within 48 hours of admission, which included the instructions to staff to provide effective person-centered care, based on the residents individual care needs, that meet professional standards of quality of care.

- Resident #134, admitted 12/27/18, with diagnose that included shortness of breath, and respiratory failure.

The physician orders, dated 12/27/18, showed respiratory treatment of Ipratropium/Albuterol

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sulfate, 0.5 mg (milligram)/3 ml (millimeters) breathing treatment, ordered 3 times a day for shortness of breath.

The baseline care plan, dated 12/28/18, lacked guidance for staff to monitor the resident's respiratory status and provide treatments. In addition, the clinical record revealed the facility failed to provide the resident and the resident representative a written summary of the baseline care plan that he/she was able to understand.

Observation, on 1/7/19 at 10:15 AM, revealed the resident with a nebulizer for respiratory treatment.

On 1/8/19 at 12:27 PM, administrative staff H stated the resident should have base line care plan within 72 hours, sometimes the nursing staff can complete the base line care plan. The care plan is the actual meeting with the resident and/or their representative. Sometimes he/she did not get around to having an initial base line care plan or meeting. The nurses should complete the base line care plan.

On 1/8/19 at 4:38 PM, social service staff E stated he/she does fill out a care plan letter and would mail the letter to the resident representative. The care plan was then given to the resident the day of the meeting, however, he/she does not document having given the resident a copy of his/her base line care plan. The resident did not have a care plan meeting yet. Staff E thought the care plan had been completed, but nothing further.

On 1/8/19 at 5:25 PM, administrative nursing staff B stated the base line care plan should be completed with each new admissions within 48

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F 655	Continued From page 8 hours. On 1/10/19 at 10:07 AM, administrative nursing staff B verified the resident/responsible person did not participate in the base line care plan meeting, or receive a written summary of the care plan. The facility failed to ensure the staff developed and implemented a base line care plan, within 48 hours of admission, which included the instructions to staff for provision of care associated with the resident's respiratory status and failed to provide the resident and/or responsible person a written summary of the plan of care, as required.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

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resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 35 residents. The sample included 13 residents sampled for review. Based on observation, interview, and record review, the facility failed to review and revise the care plan for 1 (#28) resident for interventions to prevent significant weight loss.

Findings included:

- The signed physician's orders, dated 9/20/18 of resident #28, admitted on 6/2/18, with the following diagnosis that included gastro esophageal reflux (backflow of stomach contents to the esophagus), dementia (progressive mental disorder characterized by failing memory, confusion) and Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike face, shuffling gait, muscle rigidity and weakness).

The admission MDS (minimum data set), dated 6/20/18, documented the resident had a BIMS (brief interview for mental status) score of 5, which indicated severely impaired cognition. The resident required supervision of 1 staff for eating. He/she was 63 inches tall, and weighed 145 pounds. The resident received a mechanically altered diet (foods that are altered by whipping,

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blending, grinding, chopping, or mashing so the food is easy to chew and swallow).

The cognitive CAA (care area assessment), dated 6/20/18, documented the resident had disorganized thinking, confusion, and forgetfulness. The resident received a mechanical soft diet.

The RD (registered dietician) assessment, dated 6/12/18, documented the resident had nutritional risks, related to a potential for poor intake. The resident's intake was poor. He/she recommended fortified foods (process of adding micronutrients [essential trace elements and vitamins] to food), however, the care plan lacked the revised intervention.

The quarterly MDS, dated 12/14/18, revealed the resident had a BIMS of 12, revealed moderate impairment for decision making. The resident required supervision with eating. He/she weighed 124 pounds, and had experienced a weight loss, and not on a prescribed weight-loss regimen. (14.48% weight loss in 6 months).

The dietary profile, completed by the dietary manager, dated 12/14/18, documented the resident required a mechanical soft diet, "red napkin" program, high calorie snack three times a day, and house supplement daily. His/her appetite increased recently. The resident weighed 125.6 pounds, however, the care plan lacked the revised intervention.

The ADL (activity of daily living) care plan, last reviewed 12/18/18, documented the resident required staff to remind/cue the resident to eat. Offer snacks to increase the resident's intake.

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Monitor weight and report to the resident's physician. Provide snacks, and refer to the dietician as needed. However, the care plan lacked the interventions of high calorie snacks three times a day, fortified foods, mechanical soft with ground meats/ gravy, "red napkin program, house supplement daily, and Remeron, to prevent weight loss.

The physician's orders included:

1.) 6/29/18 High calorie snack three times a day, Mechanical soft with ground meats/gravy, red napkin program, may have regular sausage, hamburger and chicken nuggets, ordered 6/13/18.

2.) Remeron, 15 milligrams, daily at bedtime, for depressive disorder, ordered 6/29/18.

3.) House supplement daily, ordered 11/15/18.

Review of the clinical records, from 6/12/18 to 1/8/19, documented on 6/12/18, staff weighed the resident, and he/she weighed 145 pounds.

On 7/10/18, staff weighed the resident, and he/she weighed 143 pounds, a 2 pound weight loss, and a total of 5.03% (percent) weight loss in 28 days (a 1.3% weight loss).

On 8/6/18, staff weighed the resident, and he/she weighed 135.8 pounds, a 7.2 pound weight loss, a total of 5.03% weight loss in less than 1 month.

On 9/11/18, staff weighed the resident, and he/she weighed 138.6, a 2.8 pound weight gain.

On 10/3/18, staff weighed the resident, and

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he/she weighed 137.8, a 0.8 pound weight loss.

On 11/2/18, staff weighed the resident, and he/she weighed 133.4 pounds, a 4.4 pound weight loss.

On 12/3/18, staff weighed the resident, and he/she weighed 122.8 pounds, a 10.6 pound weight loss.

On 1/2/19, staff weighed the resident and he/she weighed 128 pounds, a weight gain of 5.2 pounds, however, a total of 15 pounds/10.49% weight loss since 7/10/18 (a little less then 6 months).

On 1/9/19, staff weighed the resident, and he/she weighed 128.6 pounds.

Review of the registered dietician notes, from 8/10/18 to 12/11/18, identified the resident lost weight, and on 11/9/18 and 12/11/18, the resident continued to lose weight. The resident's meal intake varied from 0 to 100%. On 8/10/18, the RD documented interventions were in place. On 12/11/18, he/she recommended the addition of fortified foods. Continue to monitor the resident's weight.

On 1/7/19 at 12:31 pm, staff served the resident a hall tray. The resident slept in his/her bed, with the hall tray at his/her bedside. The resident ate one to two bites of pudding, and fell asleep.

On 1/7/19 at 1:26 pm, the resident's food tray remained at his/her bedside, and the resident ate approximately 50% of his/her pudding. The resident remained in bed, asleep.

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F 657	Continued From page 13 On 1/8/19 at 8:18 am, staff served the resident a bowl of cold cereal, no other food was on the food tray. The resident fed him/herself the cold cereal, and lacked staff cueing, as care planned for his/her nutritional risk. On 1/8/19 at 12:20 pm, staff served the resident a room tray of ground Salisbury steak, noodles, mixed vegetables, coffee, milk, and cake. His/her eating utensils had a red napkin around the utensils. Staff failed to assist the resident with the meal. On 1/8/19 at 1:40 pm, the resident's meal remained untouched. Licensed nursing staff S entered the resident's room, and failed to offer to warm up his/her meal, or offer the resident an alternative food choice. The utensils remained wrapped in the red napkin. The resident ate 0%. On 1/8/19 at 5:09 pm, a total of 4 hours and 49 minutes later, staff removed the untouched food from his/her room. The red napkin remained around the utensils. On 1/10/19 at 10:07 am, administrative nursing staff B, reported staff should review and revise the resident's care plan for current nutritional interventions. The facility lacked a policy for care plan revision. The facility failed to review and revise this resident's care plan, related to weight loss, to provide additional interventions to prevent a significant weight loss. The resident lost a total of 15 pounds/10.49% weight loss in 180 days.	F 657		
F 688	Increase/Prevent Decrease in ROM/Mobility	F 688		

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F 688 SS=D	Continued From page 14 CFR(s): 483.25(c)(1)-(3)	F 688		

§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 35 residents. The sample included 13 residents with 2 reviewed for range of motion. Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to increase/ maintain range on motion in 1(#21) of the 2 residents reviewed, to prevent decreased range of motion.

Findings included:

- The signed physician orders for resident #21, dated 3/12/17, documented the resident admitted on 3/12/17, with the following diagnosis that included a history of a fractured right humerus (a long bone in the arm that runs from the shoulder to the elbow), and edema (swelling resulting from

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an excessive accumulation of fluid in the body tissues).

The annual MDS (minimum data set), dated 3/15/18, revealed the resident had a BIMS (brief interview for mental status) score of 6, which indicated he/she had severely impaired cognition. He/she had limited range of motion on one side of the upper extremities. He/she received OT (occupational) and PT (physical therapy).

The ADL (activity of daily living) CAA (care area assessment), dated 3/20/18, documented the resident required extensive assistance with his/her ADL's. The resident required therapy.

The quarterly MDS, dated 11/30/18, documented the resident had a BIMS score of 10, and revealed the resident had moderately impaired cognition. He/she required extensive assistance with his/her ADL's, and the resident had limited range of motion on one side of his/her upper and lower extremity. The resident received OT and PT services, and restorative services of active range of motion.

The restorative care plan, dated 12/20/18, documented staff would assist with active and passive range of motion to all extremities six days a week. In addition, the skin integrity plan of care documented to assess the resident for edema.

Review of the occupational therapy notes, revealed the resident received therapy from January, 2018 to 3/15/18. The resident had edema in his/her hands, at that time.

The restorative documentation, from 12/12/18 to 1/9/19, lacked documentation of range of motion

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provided to the resident.

On 1/7/19 at 10:04 am, the resident's left hand was swollen and shiny in appearance. His/her hand positioned in a half closed fist. The resident lacked a splint or brace.

On 1/8/19 at 1:08 pm, the resident's hand remained unchanged.

On 1/9/19 at 12:34 pm, the resident's hand remained unchanged.

On 1/7/19 at 10:04 am, the resident reported he/she did not have a splint or a brace for his/her left hand, and he/she had not had therapy or restorative "for a while".

On 1/9/19 at 9:27 am, direct care staff J, identified the resident's left hand was swollen, and he/she was unaware why the resident's hand was swollen. The resident was supposed to feed him/herself, but will ask for staff assistance for eating. The resident does not try to hold cups or drinking glasses. The resident did not wear a hand splint or brace.

On 1/9/19 at 12:34 pm, licensed nursing staff I, reported the resident was not on any type of skilled therapy, and he/she was unaware if the resident received restorative therapy. Licensed nursing staff I identified the resident's left hand as edematous, and did not have braces or splints for positioning.

On 1/9/19 at 3:55 pm, direct care staff F, verified he/she did not do any restorative services on the resident due to his/her "case overload". He/she discontinued the resident's program on 11/28/18,

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(a month and 12 days ago). Direct care staff F reported as long as the resident could move his/her arms or legs when staff assisted with his/her dressing or transfers, that movement would be enough for the resident. Staff should put a hand protector in his/her left hand due to the contracture (abnormal permanent fixture of a joint) to his/her hand. He/she verified staff no longer place a hand protector in the resident's hand. After the resident completed therapy, restorative staff was supposed to do restorative services, but verified he/she did not after 11/28/18.

On 1/9/19 at 4:07 pm, direct care staff J, reported staff did not do any type of a restorative program on the resident, but staff did turn him/her from side to side in his/her bed, and when the resident grabbed the transfer rail, that could be documented as restorative services.

On 1/9/19 at 4:20 pm, consultant staff L, verified staff should not include ADL cares as a restorative program.

On 1/10/19 at 10:07 am, administrative nursing staff B, reported he/she was unaware the resident no longer received restorative services, and was unaware who should be over the restorative program.

The facility's policy for restorative program, dated 3/2014, documented the facility would develop a restorative nursing program that was resident driven and specific and to aide in the design of programs that enabled a resident to maintain their highest level of functioning.

The facility failed to provide appropriate treatment

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F 688	Continued From page 18 and services to increase/ maintain range of motion, for this resident who had a left hand contracture, to prevent decreased range of motion.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. The facility identified 6 residents as confused and self-mobile. The facility failed to keep hazardous chemicals out of reach, for these 6 confused residents. Findings included: - The facility identified 6 residents as confused and self-mobile. Observations during the initial tour of the facility, on 1/7/19 at 8:17 am, revealed the following items of concern: East Hall community shower room 1.) One bottle with approximately 500 milliliters of "Clorox germicidal spray" in a cabinet, labeled keep out of reach of children. 2.) Two bottles of "virex" disinfectant cleaner labeled keep out of reach of children, stored on	F 689		

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top of the resident's towel cabinet.

3.) A commode basin, stored directly on the shower room floor, had an unidentified blue substance in the commode basin.

West hall community shower room

1.) One bottle of liquid toilet bowl cleanser was in an unlocked cabinet. The label documented to keep of out reach of children.

2.) A bottle that had approximately 1/2 gallon of germacidal disinfectant stored in the unlocked shower room.

3.) A bottle that had approximately 3/4 gallon of "turbo clean", stored in the unlocked shower room.

On 1/7/19 at 8:21 am, licensed nursing staff R, verified the chemicals in the east hall. He/she was unaware of the cleaning solution placed in the commode basin.

On 1/7/19 at 9:15 am, maintenance staff V, verified the unlocked cabinets. He/she reported staff should keep hazardous chemicals locked in the cabinets.

On 1/8/19 at 5:25 pm, administrative nursing staff B, reported staff should lock hazardous chemicals out of the resident's reach.

The facility's undated policy for housekeeping, laundry and maintenance, documented the facility would be kept free of safety hazards using standard procedures and work methods.

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F 689	Continued From page 20 The facility failed to keep hazardous chemicals out of the reach of the 6 confused, mobile residents.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. The sample included 13 residents, with 2 residents sampled for nutrition. Based on observation, interview, and record review, the facility failed to ensure 1 (#28) of the 2 sampled residents maintained adequate nutrition. The resident experienced a significant weight loss, a total of 15 pounds/10.49% weight loss in 180 days.	F 692		

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Findings included:

- The signed physician's orders, dated 9/20/18 of resident #28, admitted on 6/2/18, with the following diagnosis that included gastro esophageal reflux (backflow of stomach contents to the esophagus), dementia (progressive mental disorder characterized by failing memory, confusion) and Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike face, shuffling gait, muscle rigidity and weakness).

The admission MDS (minimum data set), dated 6/20/18, documented the resident had a BIMS (brief interview for mental status) score of 5, which indicated severely impaired cognition. The resident required supervision of 1 staff for eating. He/she was 63 inches tall, and weighed 145 pounds. The resident received a mechanically altered diet (foods that are altered by whipping, blending, grinding, chopping, or mashing so the food is easy to chew and swallow).

The cognitive CAA (care area assessment), dated 6/20/18, documented the resident had disorganized thinking, confusion, and forgetfulness. The resident received a mechanical soft diet.

The RD (registered dietician) assessment, dated 6/12/18, documented the resident had nutritional risks, related to a potential for poor intake. The resident's intake was poor. He/she recommended fortified foods (process of adding micronutrients [essential trace elements and vitamins] to food).

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The quarterly MDS, dated 12/14/18, revealed the resident had a BIMS of 12, revealed moderate impairment for decision making. The resident required supervision with eating. He/she weighed 124 pounds, and had experienced a weight loss, and not on a prescribed weight-loss regimen. (14.48% weight loss in 6 months.

The dietary profile, completed by the dietary manager, dated 12/14/18, documented the resident required a mechanical soft diet, "red napkin" program, high calorie snack three times a day, and house supplement daily. His/her appetite increased recently. The resident weighed 125.6 pounds.

The ADL (activity of daily living) care plan, dated 12/18/18, documented the resident required staff to remind/cue the resident to eat. Offer snacks to increase the resident's intake. Monitor weight and report to the resident's physician. Provide snacks, and refer to the dietician as needed.

The physician's orders included:

1.) 6/29/18 High calorie snack three times a day, Mechanical soft with ground meats/gravy, red napkin program, may have regular sausage, hamburger and chicken nuggets, ordered 6/13/18.

2.) Remeron, 15 milligrams, daily at bedtime, for depressive disorder, ordered 6/29/18.

3.) House supplement daily, ordered 11/15/18.

Review of the clinical records, from 6/12/18 to 1/8/19, documented on 6/12/18, staff weighed the resident, and he/she weighed 145 pounds.

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F 692	Continued From page 23 On 7/10/18, staff weighed the resident, and he/she weighed 143 pounds, a 2 pound weight loss, and a total of 5.03% (percent) weight loss in 28 days (a 1.3% weight loss). On 8/6/18, staff weighed the resident, and he/she weighed 135.8 pounds, a 7.2 pound weight loss, a total of 5.03% weight loss in less than 1 month. On 9/11/18, staff weighed the resident, and he/she weighed 138.6, a 2.8 pound weight gain. On 10/3/18, staff weighed the resident, and he/she weighed 137.8, a 0.8 pound weight loss. On 11/2/18, staff weighed the resident, and he/she weighed 133.4 pounds, a 4.4 pound weight loss. On 12/3/18, staff weighed the resident, and he/she weighed 122.8 pounds, a 10.6 pound weight loss. On 1/2/19, staff weighed the resident and he/she weighed 128 pounds, a weight gain of 5.2 pounds, however, a total of 10.49% weight loss since 7/10/18. On 1/9/19, staff weighed the resident, and he/she weighed 128.6 pounds. Review of the medication administration record, from 11/1/18 to 1/10/19, documented staff administered the house supplement, however, the clinical records lacked the amount of the supplement. On 1/7/19, staff changed the snack from 10:00 am, 4:00 pm, and 6:00 pm, to 10:00 am, 2:00 pm, and bedtime.	F 692		

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Review of the registered dietician notes, from 8/10/18 to 12/11/18, identified the resident lost weight, and on 11/9/18 and 12/11/18, the resident continued to lose weight. The resident's meal intake varied from 0 to 100%. On 8/10/18, the RD documented interventions were in place. On 12/11/18, he/she recommended the addition of fortified foods. Continue to monitor the resident's weight.

On 1/7/19 at 12:31 pm, staff served the resident a hall tray. The resident slept in his/her bed, with the hall tray at his/her bedside. The resident ate one to two bites of pudding, and fell asleep.

On 1/7/19 at 1:26 pm, the resident's food tray remained at his/her bedside, and the resident ate approximately 50% of his/her pudding. The resident remained in bed, asleep.

On 1/8/19 at 8:18 am, staff served the resident a bowl of cold cereal, no other food was on the food tray. The resident fed him/herself the cold cereal, and lacked staff cueing, as care planned for his/her nutritional risk. Staff failed to offer the resident any other food items, including fortified foods.

On 1/8/19 at 12:20 pm, staff served the resident a room tray of ground Salisbury steak, noodles, mixed vegetables, coffee, milk, and cake. His/her eating utensils had a red napkin around the utensils. Staff failed to assist the resident with the meal.

On 1/8/19 at 1:40 pm, the resident's meal remained untouched. Licensed nursing staff S entered the resident's room, and failed to offer to

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warm up his/her meal, or offer the resident an alternative food choice. The utensils remained wrapped in the red napkin. The resident ate 0%.

On 1/8/19 at 5:09 pm, a total of 4 hours and 49 minutes later, staff removed the untouched food from his/her room. The red napkin remained around the utensils.

On 1/8/19 at 5:14 pm, direct care staff K, reported staff should pick up hall trays after meals.

On 1/9/19 at 9:27 am, direct care staff J, reported he/she was unaware if the resident ate his/her snacks. The resident required cueing at every meal. The resident "doesn't stay awake long enough to eat". Staff will pick his/her meal choices if the resident did not like the choices, but might still eat a few bites. The resident required a lot of time for eating any meal. At times, the resident complained that his/her food had turned cold. Staff seldom warmed the resident's meal, and staff reported he/she did not ask the resident for alternate food choices.

On 1/9/19 at 12:34 pm, licensed nursing staff I reported the resident "was probably losing weight". The red napkin around the utensils identified the resident as a nutritional risk, and alerted staff to monitor the resident's intake of food. Staff should offer the resident alternatives, and the resident ate slow, and would take the resident "a good hour" for him/her to eat a meal. Staff should warm the resident's food up after 15 minutes, to maintain the temperature, because he/she ate slowly. The resident required set up assistance for his/her meals. The facility did not use snack carts, and did not ask each resident if they would want a snack, because snacks were

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available only if the resident informed staff they were hungry.

On 1/10/19 at 10:07 am, administrative nursing staff B, verified the resident lost weight. If staff could keep the resident awake, the resident ate fairly well. He/she was unaware if the resident's medications of Tramadol for pain, or Hydroxyzine for his/her itch (both of which have side effects of extreme drowsiness), affected the resident's sleeping/ eating. The resident requires a lot of time for eating, because he/she ate slowly, sometimes over 1 hour to complete his/her meals. Staff does not offer to warm up his/her plates of food. Staff should supervise the resident with all his/her meals, to increase his/her consumption of food.

On 1/10/19 at 11:00 am, dietary staff C identified the resident was at risk for weight loss, because the resident slept a lot. Staff served the resident fortified foods as he/she was on the red napkin program. Staff should warm up the resident's food if the food sat more than 10 minutes.

On 1/15/19 at 12:58 pm, physician's consultant staff BB, reported the resident slept a lot because of pain management. Staff should supervise, cue, and assist the resident with meals. If staff would assist the resident, and make sure the meals were the correct temperature, then the weight loss may have been avoidable.

The facility's policy for weight assessment and intervention, revised 2015, documented the interdisciplinary team would strive to prevent, monitor, and intervene for the undesirable weight changes of residents.

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F 692	Continued From page 27 The facility failed to cue and assist the resident, as care planned, failed to keep the resident's food at an acceptable temperature, and failed to offer alternatives for this resident who lost weight, to ensure the resident maintained adequate nutrition. The resident experienced a significant weight loss, a total of 15 pounds/10.49% weight loss in 180 days.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. The sample included 13 residents with 1 resident sampled for oxygen/ respiratory services. Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for the 1(#134) resident sampled who required physician ordered inhalation treatments. Findings included: - Resident #134, admitted 12/27/18, with the following diagnosis that included shortness of breath. The admission MDS (minimum data set), dated	F 695		

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1/9/19, revealed the resident's BIMS (brief interview for mental status) score of 14, the resident had no cognitive impairment. The resident did not have shortness of breath, and did not require oxygen supplementation.

The CAA (care area assessment), dated 1/9/18, documented the resident had respiratory failure at the hospital prior to his/her admission to the facility.

The baseline care plan, dated 12/28/18, lacked guidance for respiratory treatments. In addition, the facility failed to provide the resident and the resident representative a written summary of the baseline care plan that he/she was able to understand.

The physician's orders included Ipratropium Bromide, albuterol sulfate, 0.5 milligrams/ 3 milliliters, for shortness of breath, ordered 12/27/18. However, the frequency documented three times a day, and the "prescription detail" documented the resident to have the inhalation four times a day.

Review of the MAR/TAR (medication/ treatment administration record), from 1/1/18 to 1/8/18, revealed the resident received the inhalation treatment three times a day.

Observation, on 1/7/19 at 10:15 am, revealed the resident's inhalation chamber stored upright, attached to the inhalation machine, and had liquid and moisture in the chamber.

On 1/8/19 at 9:26 am, the resident's inhalation chamber had liquid in the medication chamber. The resident reported staff administered his/her

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last inhalation treatment in the evening, on 1/7/19.

On 1/8/19 at 11:39 am, the resident's inhalation chamber remained unchanged.

On 1/8/19 at 11:53 am, the resident was in his/her bed, unsupervised, with the inhalation treatment being administered.

On 1/8/19 at 1:13 pm, the resident's inhalation chamber had liquid in the medication chamber.

On 1/8/19 at 5:19 pm, the resident's inhalation chamber remained unchanged.

On 1/8/19 9:26 am, licensed nursing staff I, verified he/she had not administered any of the resident's scheduled inhalation treatment for the day.

On 1/8/19 at 5:24 pm, licensed nursing staff I, reported staff should have contacted the physician for a clarification order for the frequency of the inhalation treatment. He/she verified that he/she failed to rinse the inhalation treatment after each use, and was aware the inhalation chamber should have been rinsed and air dried for infection control purposes to prevent respiratory infections.

On 1/8/19 at 5:25 pm, administrative nursing staff B, reported staff should have clarified the physician's order for the inhalation treatment. He/she verified the order documented three times and day, in addition to four times a day. Staff failed to send the hospital discharge orders to the physician for review and signature.

The facility lacked a policy for inhalation therapy.

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F 695	Continued From page 30 The facility failed to clarify the physician order for the number of times the resident should receive the respiratory treatment and failed to cleanse the medication chamber appropriately after providing the treatment to ensure proper infection control practices to prevent respiratory infections.	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		

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by:
The facility reported a census of 35 residents. Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide care for the residents, based on their individualized care needs.

Findings included:

- Review of the facility assessment, revised 12/14/18, documented based on the resident population and their care needs, the average nurse aides would be 10- 8 hour shift positions a day.

The Resident Census and Condition form, dated 01/07/19, evidenced the following:

Bathing - 24 residents required assist of one or two staff and 11 residents were dependent on staff.

Dressing - 33 residents required assist of one or two staff and 1 was dependent.

Transferring - 30 residents required assist of one or two staff and 3 were dependent.

Toilet Use - 31 residents required assist of one or two staff and 3 were dependent.

Eating - 24 residents required assist of one or two staff and 2 were dependent.

On 1/8/19 at 5:10 pm, observation revealed two residents lunch trays remained in the residents rooms. Staff failed to pick up the lunch trays after the noon meal (5 hours later).

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On 1/7/19 at 8:35 am, one resident reported staff did not answer his/her call lights timely, and it felt like he/she waited approximately 2 hours before on staff to answer the call light.

On 1/7/19 at 9:11 am, another resident reported staff failed to answer his/her call light timely. Staff always had an "excuse" not to answer the call light on time, because staff was busy and doing "other things". He/she would wait until staff walked by his/her door, and the resident would yell out for help.

On 1/7/19 at 10:14 am, another resident reported there was not enough staff to answer his/her call light, and would have to yell for assistance, instead of waiting for staff to answer the call light.

On 1/8/19 at 1:03 pm, another resident's lunch tray sat on his/her bedside table. The resident reported he/she had not eaten lunch yet, because he/she was incontinent, and had turned the nurse call light on for assistance with his/her incontinence. At 1:19 pm, licensed nursing staff R entered the resident's room, and informed the resident he/she would return with another staff for assistance. At 1:22 pm, 19 minutes after the resident turned on the call light, licensed nursing staff R and direct care AA, entered the resident's room, to give incontinence care.

On 1/7/19 at 1:42 pm, another resident's family member reported the facility did not have enough nursing staff to care for his/her family. Staff are too busy they cannot get everything done. Staff scheduled the resident for 2 baths a week, and it is not unusual to miss out on his/her bath at least weekly. Staff cannot get the resident toileted "enough", and he/she generally has to go find a

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staff member to take the resident to the toilet.

On 1/7/19 at 3:41 pm, another resident's family member reported there was not enough staff to effectively care for the resident. The resident has to wait a long time, and family had to "track" staff down, for the resident to receive staff assistance.

On 1/7/19 at 11:00 am, administrative nursing staff B, verified staff were unable to pass snacks this morning, because of insufficient nursing staff.

On 01/08/19 at 5:14 pm, direct care staff K, reported staff should pick up residents hall trays after meal time, and he/she was unaware the 2 residents still had their lunch trays in the room.

On 1/8/19 at 5:37 pm, administrative nursing staff B, verified staffing was insufficient to make sure the residents received cares. The charge nurses should help answer some of the residents call lights. He/she verified on 1/4/19, there was only 1 cna for the 6:00 am to 6:00 pm shift. A transportation driver helped out until he/she took some of the residents for a casino trip. Staff should transfer a resident who required a mechanical lift with 2 staff, unless the resident had a urinary catheter, then staff should use 3 staff. He/she verified at times there were not enough nursing staff for 3 cna's to be in a resident's room.

On 1/8/19 at 5:58 PM, licensed nursing staff I, stated charge nurses did not have nurse call pagers, and he/she did not know when a resident would require assistance, unless a direct care staff asked him/her to assist with cares.

On 1/8/19 at 8:40 am, licensed nursing staff S,

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identified the medication assistant called in, and was unable to find a replacement. He/she was "pulled" from wound care assessments, to pass medications. He/she failed to carry a nurse call pager, but had "helped staff yesterday without having a (nurse call) pager".

On 1/8/19 at 6:00 pm, direct care staff O identified nursing staff works "short", and it was difficult for him/her to make sure the residents received adequate nursing care.

On 1/8/19 at 6:02 pm, direct care T reported staff attempt to get all the residents to bed, with the exception of one resident, who will not go to bed before 10:00 pm, related to not enough staffing after 10:00 pm.

On 1/8/19 at 6:14 pm, direct care staff K, reported nursing staff frequently had to work "short". On 1/4/19, he/she was the only cna working due to staff "call in". When there was not enough nursing staff, he/she was unable to complete the residents scheduled bathing, toileting, repositioning, according to their individual care plans. If a resident had a skin issue, staff attempted to do the repositioning for those residents, but verified if the resident did not have an open area, staff did not get the residents repositioned. The residents might be toileted twice in 12 hours. Staff had to work short "a lot". On occasion, because of staff shortage, staff have to transfer residents in a mechanical lift with 1 staff assistance, instead of 2 staff.

On 1/8/19 at 6:15 pm, direct care staff G, identified the residents lacked bathing, toileting, and repositioning according to the residents care plan. When staffing is short, managers were

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aware that there was not enough staff to safely transfer a resident that required a mechanical lift, because staff supposed to use 2 staff for mechanical lift transfers, and sometimes there isn't enough help to get 2 staff.

On 1/8/19 at 6:18 pm, direct care staff U, reported there was not enough staff for the residents to receive proper cares. Sometimes there is only 1 cna after 10:00 pm, and there should be 2 cna's from 10:00 pm to 6:00 am, and 1 cna from 6:00 pm to 10:00 pm. The charge nurse might occasionally enter a resident's room, only to come out and tell the cna's that a resident needed to use the toilet, and staff would go in when they could. Occasionally, staff was unable to give the residents their scheduled baths. After supper, staff attempt to get everyone in bed before 10:00 pm, before the 6:00 pm to 10:00 pm shift left. Some of the residents are "put to bed at the wrong time", in order to get the residents in bed before 10:00 pm. If a confused resident is awake, and not wanting to stay in bed, they have an increased risk for falls.

On 1/9/19 at 9:27 am, direct care staff J, reported he/she was unaware why there were 4 cna's working on the shift, because there are supposed to be 3 staff on the floor. Staff was unable to get the resident's toileted on time, and sometimes staff had to transfer a resident on a mechanical lift with 1 staff. At times, residents do not get to the dining room on time. There is an increase of incontinent residents when shift change is completed, because there wasn't enough cna's to do the last bedcheck. When a resident calls for a nurse, it sometimes takes a long time for staff to get the call light answered, because if a cna is in the middle of something, staff can't leave that

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resident to answer another resident's call light. If staff can't get the call lights answered, some of the residents would just start yelling out for assistance.

On 1/9/19 at 3:55 pm, direct care staff F, verified he/she did not do any restorative services for resident #21, related to staff had too many residents for restorative, and he/she discontinued the services because of the "case overload."

On 1/9/19 at 4:20 pm, consultant staff L, identified the facility policy for transferring a resident with a mechanical lift, required 2 staff members to safely transfer a resident.

Furthermore, the facility failed to provide sufficient nursing staff as evidenced by the following:

Refer to F688 - the facility failed to provide appropriate treatment and services to increase/ maintain range on motion in 1(#21) of the 2 residents reviewed, to prevent decreased range of motion.

Refer to F692 - the facility failed to ensure 1 (#28) of the 2 sampled residents maintained adequate nutrition. The resident experienced a significant weight loss, a total of 15 pounds/10.49% weight loss in 180 days.

The facility policy for personnel policies, dated 6/4/14, documented the administrator would be responsible to assure staffing guidelines met quality care to the customers and all regulatory requirements. Staffing should be kept at levels to assure services are provided.

The facility failed to to have sufficient nursing staff

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F 725	Continued From page 37 to ensure residents received care based on their identified individualized needs.	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. Based on record review and interview, the facility failed to ensure direct care staff, employed over a year, had at least 12 hours of education. Findings included: - Review of the employee records revealed the following staff lacked 12 hours of education, in the past year: Direct care staff Z, hired on 3/15/17, with 6.25 hours of training. Direct care staff P, hired on 2/15/16, with 7.25 hours of training. Direct care staff N, hired on 5/30/17, with 8.25 hours of training. Direct care staff O, hired on 3/22/16, with 8 hours of training. Review of the facility assessment, revised	F 730		

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F 730	Continued From page 38 12/14/18, documented the facility would complete staff training education. On 1/8/19 at 2:44 pm, administrative staff A, verified staff failed to complete 12 hours of education. He/she was aware the facility should monitor for direct care staff training hours. The facility policy for personnel policies, dated 6/4/14, documented the administrator would be responsible to assure staffing guidelines met quality care to the customers and all regulatory requirements. The facility failed to ensure direct care staff, employed over a year, completed at least 12 hours of education, to ensure appropriate care provided for the residents of the facility, based on their individual care needs.	F 730		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		

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consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 35 residents. The sample included 13 residents, with 5 residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to monitor 1 (#21) of the 5 sampled residents unused medications, to ensure the resident remained free from unnecessary medications.

Findings included:

- The signed physician's orders, signed 12/7/18, of resident #21, documented the resident admitted on 3/12/17, with a diagnosis that included pain.

The physician's order included Tramadol, 50 milligrams, every 4 hours, prn (as needed), for pain, ordered 7/29/18.

Review of the MAR (medication administration record), revealed staff did not administer the prn Tramadol from 07/2018 to 1/10/19.

On 1/10/19 at 10:07 am, administrative nursing staff B, reported staff should monitor for unused prn medication, and contact the physician if a medication was not used. He/she reported the pharmacist would make those recommendations, however, he/she reported the facility lacked a system in place for monitoring unused prn's.

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F 757	Continued From page 40 The facility lacked a policy for monitoring unused prn medications. The facility failed to monitor this resident for unused prn Tramadol, to ensure the resident remained free from unecessary medication use.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		

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	175264	A. BUILDING _____ B. WING _____	01/10/2019

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F 758	Continued From page 41 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents, with 13 sampled and 5 reviewed for unnecessary medication. Based on observation, record review, and interview, the facility failed to ensure 2 of the 5 residents remained free from unnecessary psychotropic medications. The facility failed to complete an initial psychotropic medication assessment such as an AIMs (abnormal involuntary movement scale) or Discus (dyskinesia identification system condensed user scale), (both used to monitor the resident for the development of abnormal involuntary movements, such as hand tremors or rhythmic movements of the tongue and jaw, that may result from the long-term administration of psychotropic drugs), after the physician ordered a antipsychotic medication, for 2 of the 5 resident's reviewed #19 and #21's who lacked an AIMs or Discus assessment.	F 758		

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F 758	Continued From page 42	F 758		

Findings included:

- Resident #19's, signed physician orders, dated 12/7/18, documented the resident admitted on 4/26/18, with the following diagnoses including; psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) not due to a substance or known physiological condition.

The admission MDS (minimum data set), dated 5/3/18, revealed the resident had a BIMS (brief interview for mental status) score of 5, indicating severely impaired cognition. The resident had a mood score of 0, and without behaviors. The resident required extensive staff assistance for bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene; limited staff assistance for walking; and supervision for eating. The resident received a antibiotic (a drug used to treat bacterial infections) medication only. The resident did not receive any psychotropic medication.

The CAA (care area assessment), for cognition dated 5/16/18, documented the resident had noted memory and memory recall problems. He/she was able to make his/her needs known per staff interview and required time to answer questions, and staff may have to repeat the question for him/her as the resident was slower to answer some questions.

The CAA for psychotropic medication did not trigger.

The resident discharged to a behavioral health facility on 11/1/18, and returned from the

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behavioral health facility on 11/13/18.

The 14 day MDS, dated 11/27/18, revealed the following changes only from the admission MDS dated 5/3/18: The resident with a mood score of 1, which indicated minimal mood/depression, and without behaviors. The resident required for walking extensive staff assistance. The resident without pain and without falls. The resident weighed 161 pounds, with weight loss and on a physician-prescribed weight-loss regimen, and received a mechanically altered diet. The resident received a antipsychotic, antidepressant (a mood medication), and a diuretic (fluid loss medication).

The care plan, reviewed on 12/12/18, for mood and/or behaviors documented the following:
--Medication review with psychiatrist/facilitypharmacist/ doctor.
--Observe mood and behaviors.
--Obtain psychiatric evaluation as indicated and ordered.
--Redirect aggressive behavior with alternative activities

The resident returned from a behavioral health facility on 11/13/18, with the following physician orders:
1.) Risperdal, 0.5 mg (milligrams), 1 by mouth daily for psychosis not due to a substance or known physiological condition.
2.) Risperdal, 0.5 mg, 1 by mouth twice daily for psychosis not due to a substance or known physiological condition.

The resident's electronic assessment record or paper record from 11/13/18 through 1/9/19 lacked an AIMS (abnormal involuntarily movement score), or DISCUS or any other psychotropic

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medication assessment for this resident who started the antipsychotic medication, Risperdal on 11/13/18, for psychosis (an abnormal condition the mind that results in difficulties determining what is real and what is not.)

On 1/8/19 at 12:10 PM, the resident sat in the dining room with a plate of Salisbury steak, parmesan noodles, vegetable blend, and jello cake. The resident's spouse encouraged the resident to eat.

On 1/8/19 at 2:30 PM, the resident sat in his/her wheelchair with his/her room with the spouse present, and without behaviors.

On 1/9/19 at 3:50 PM, licensed nursing staff I verified the resident's medical record lacked an AIMS or DISCUS assessment

On 1/10/19 at 10:08 AM, administrative nursing staff B stated the nurses should complete a DISCUS when the physician ordered the antipsychotic medication.

The facility policy for behavior management and psychotropic medication dated 12/16, advised the the AIMS or DISCUS assessments are to be completed on admission, readmission, quarterly, with the significant change, and with initiation of an antipsychotic medication.

The facility failed to ensure completion of an assessment of the resident to monitor the resident for side effects associated with the use of an antipsychotic medication and to prevent unnecessary use of a medication.

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- Resident #21's, signed physician orders, dated 12/7/18, documented the resident admitted on 3/12/17, with the following diagnoses including; dementia (progressive mental disorder characterized by failing memory, confusion) with behavior, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and sexual disorder.

The annual MDS (minimum data set) dated 3/15/18, revealed the resident with a BIMS (brief interview for mental status) score of 6, indicating severely impaired cognition. The resident with a mood score of 0 and without behaviors. The resident received a antianxiety, antibiotic, and a diuretic medication.

The CAA (care area assessment), dated 3/20/18, for psychotropic medication, advised the resident received routine lorazepam, an antianxiety medication, for a anxiety disorder. The facility pharmacist to review the resident's medications monthly per facility protocol, and behaviors are monitored via plan of care documentation.

The quarterly MDS, dated 11/30/18, revealed the resident had a BIMS score of 10, indicating moderately impaired cognition, without behaviors or mood concerns. The resident received 2 additional medications, a antipsychotic (class of medication used to manage pyschosis [an abnormal condition the mind that results in difficulties determining what is real and what is not.]) and an opioid medication.

The care plan, reviewed on 12/20/18, for psychotropic medication use documented the resident used therapeutic psychotropic medications.

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The physician ordered on 11/16/18, Paliparidone ER (extended release), an antipsychotic medication, 1.5 mg. (milligrams) daily for unspecified dementia with behavioral disturbance.

The facility lacked an AIMS (abnormal involuntarily movement score), DISCUS (Dyskinesia Identification System Condensed User Scale) or any other psychotropic medication assessment for this resident who started Paliparidone on 11/17/18, for unspecified dementia with behavioral disturbance.

On 1/8/19 at 1:8 PM, the resident in a wheelchair in the hallway without behaviors.

On 1/9/18 at 8:00 AM, the resident without behaviors.

On 1/9/19 at 3:52 PM, licensed nursing staff I stated the licensed nursing staff should have done DISCUS or and AIMS, and verified the resident did not have either assessment although the resident received an antipsychotic medication.

On 1/10/19 at 10:07 AM, administrative nursing staff B stated the antipsychotic medication assessments should be looked at daily Monday thru Friday. The facility used the DISCUS assessment for psychotropics, and the assessment should be completed before starting the medication.

The facility policy for behavior management and psychotropic medication, dated 12/16, advised the the AIMS or DISCUS assessments are to be

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F 758	Continued From page 47 completed on admission, readmission, quarterly, with the significant change, and with initiation of an antipsychotic medication. The facility failed to ensure completion of an assessment of the resident to monitor the resident for side effects associated with the use of an antipsychotic medication and to prevent unnecessary use of a medication.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced	F 761		

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by:
The facility reported a census of 35 residents. Based on observation, record review, and interview, the facility failed to ensure proper labeling of individual insulin pens including lack of instructions of dosage for administration of the insulin and lack of an open date of the insulin pens, failed to ensure outdated medications were removed, and failed to ensure staff locked the medication cart to ensure safe storage of medications.

Findings included:

- On 1/7/19 at 9:00 AM, initial inspection of 1 of 2 licensed nurses cart, with licensed nursing staff R, revealed:

1.) A Novolog insulin pen for resident #1 lacked instructions on the pen for the administration. Nursing staff R stated the staff would look on the electronic MAR (medication administration record) to see how much insulin the physician ordered, and also the label was on the box the insulin pen came in, which was kept in the medication room.

2. A card of 60 and a card of 15 tablets of Tramadol (pain medication), 50 mg (milligrams), 1 by mouth every 4 hours as needed for pain, for resident #10, had an expiration date of 12/18. Staff R stated the resident had not received the medication since it had expired, and the licensed nursing staff should have identified the medication had expired and removed it.

3.) An opened insulin vial of Novolog 70/30, for resident #32, lacked an open date.

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4.) A Novolog insulin pen, for resident #4, lacked instructions on the pen for administration. Licensed nursing staff S stated the directions for the insulin administration was on the electronic MAR.

Interview, on 1/10/19 at 11:00 AM, with administrative nursing staff B stated the insulin pens or insulin vial should have the date opened on them. Furthermore, staff were to check medication for expiration.

The facility policy for medications and medication labels, dated 2007, advised for medications designed for multiple administration, (for example, inhalers or eye drops), a label is affixed to the product to assure proper resident identification.

The facility failed to ensure proper labeling of insulin including dosage and open dates and failed to monitor expiration dates of medications to ensure the safe storage and use of these medications.

- On 1/8/19 at 8:34 am, during medication observation, licensed nursing staff S, closed the medication cart drawer, and walked away from the medication cart, into another room, and left the unlocked medication cart unattended, with the keys on a lanyard, which remained in the keylock of the medication cart.

On 1/8/19 at 8:40 am, licensed staff S stated he/she was aware staff should not leave the medication cart unattended.

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F 761	Continued From page 50 Interview, on 1/10/19 at 11:00 AM, with administrative nursing staff B stated the medication cart should not be left unlocked. The facility failed to ensure, during a medication pass, the medications were under the direct observation of the person administering the medications or locked in the medication storage area/cart.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions to prevent the potential spread of food borne illnesses to the residents.	F 812		

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F 812	Continued From page 51	F 812		

Findings included:

- On 1/7/19 at 8:008 AM, during the initial tour of the kitchen, identified the following areas of concern:

1.) The 2 door refrigerator contained a package of opened diced ham with a opened date of 12/27/18.

2.) A covered container of refried beans lacked a date of when staff placed the refried beans in the container.

3.) A covered container of turkey gravy, with a date of 12/26/18.

4.) A covered container of tomato's and zucchini, with a date of 12/30/18.

5.) A covered container of Mexican corn, with a date of 12/30/18,

6.) A covered container of pork gravy, with a date of 12/30/18

On 1/7/19 at 8:20 AM, dietary staff Q stated food should be held for only 3 days and all food should be dated.

On 1/7/19 at 8:22 AM, dietary staff X stated it was everyone's job to monitor food for an expiration date.

The facility policy dated 2016, documented prepared food or opened food items should be discarded when the food item is left over for more than 72 hours.

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F 812	Continued From page 52 The facility failed to store and prepare food under sanitary conditions to prevent the potential spread of food borne illnesses to the residents. - During a tour of the dietary department, on 1/9/19 at 1:46 pm, revealed the following items of concern: 1.) Four cutting boards contained deep cuts, creating a non-cleanable surface. 2.) Two non-stick skillets, with flaking non-stick surfaces throughout the insides. On 1/9/19 at 1:46 pm, dietary staff C stated, the facility did not have a policy for replacing cutting boards and skillets." The facility failed to store, prepare, distribute, and serve food under sanitary conditions for the residents of the facility.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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F 880	Continued From page 53 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 54 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents, with 17 residents sampled for review. Based on observation, interview, and record review, the facility failed to provide proper infection control practices to prevent cross contamination and the spread of infection, including dirty linens on the floor, bed pans, urine graduates (containers used for the collection and measurement of urine output) and urinary drainage bags improperly stored, and trash cans which sat on top of a commode and a bedside table. Findings included: - Observation, on 1/7/19 at 9:00 am, revealed dirty towels, linen, and a discarded glove placed directly on the floor in resident #11's room. The resident reported he/she had a family member in on 1/6/18, who trimmed his/her hair, and left the items on the floor, however, he/she felt staff should have picked up the soiled linens. In addition, a bath basin and a bed pan stored directly on the resident's bathroom floor. There were 2 graduates (containers used for collection	F 880		

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	175264	A. BUILDING _____ B. WING _____	01/10/2019

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F 880	Continued From page 55	F 880		

and measurement of urine output) with dried yellow substance in the bottom, and the graduates stored directly on the toilet lid.

On 1/7/19 at 1:38 pm, resident #8, had two urine graduates (container used for measurement) placed open side down, drying on a paper towel on the top of his/her shared bathroom toilet tank lid, and a bath basin stored directly on the floor.

On 1/7/19 at 10:42 am, direct care staff G, reported staff should store the resident's urine graduates and bath basins in plastic bags, and staff should not place the items directly on the floor or the top of the toilet tank lids.

On 1/10/19 at 10:07 am, administrative nursing staff B, reported staff should store urine collection graduates, bedpans, and bath basins in a plastic bag in the resident's bathroom.

The facility's policy for infection management process, revised 12/2017, documented the infection management process would assist the facility with prevention and managing infection events.

The facility failed to provide proper infection control practices to prevent cross contamination and transmission of infections.

- On 1/7/19 at 8:30 AM, during initial screening of the residents, revealed the following concerns:

1.) One resident's room contained a commode with a trash can on top of it and a bag with clothes sitting on the commode.

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F 880	Continued From page 56 2.) One resident's room contained a trash can on top of a bedside table. 3.) Observation, in resident #16's room revealed a catheter drainage bag hanging on a trash can, without a dignity cover (a cloth bag), and the drainage bag touched the floor. On 1/10/19 10:35 AM, administrative staff B stated, he/she and Licensed staff S are responsible for training of the staff on infection control, the staff should not be hanging catheters on trash cans, the catheters should be covered with dignity covers, the trash cans should not be on the bedside tables. This is an education problem. The facility policy, revised 12/17, documented the management process will assist the facility with preventing and managing infection events. Employees will be provided with education on infection management and prevention during orientation. The facility failed to provide proper infection control practices to prevent cross contamination and transmission of infections for these 3 residents.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents.	F 921		

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F 921	Continued From page 57	F 921		

Based on observation and interview, the facility failed to provide maintenance services in one central supply room and one restorative closet, to ensure a safe and sanitary environment.

Findings included:

- Observation on 1/7/19 at 8:17 am, revealed a closet identified as the restorative aide closet, revealed multiple resident use positioning devices stored directly on the floor.

On 1/7/19 at 8:25 am, direct care staff F, verified the items on the floor, and reported he/she had not had time to pick items up off the floor.

Observation on 1/7/19 at 8:37 am, a central supply room had the following items stored directly on the floor:

1.) A carton that contained disposable teaspoons.

2.) Six cardboard boxes, filled with miscellaneous medical supplies.

3.) One gallon of bleach.

4.) One gallon of disinfectant.

On 1/7/19 at 8:37 am, administrative staff A, verified the items on the central supply room floor.

The facility's undated policy for housekeeping, laundry and maintenance, documented the departments must maintain the interior and furnishings in a clean, orderly, and attractive manner.

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F 921	Continued From page 58 The facility failed to ensure maintenance/housekeeping in the central supply room and restorative closet to ensure a safe, sanitary environment for the staff in the facility.	F 921		