

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

PRINTED: 08/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2018
NAME OF PROVIDER OR SUPPLIER THE NICOL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 303 E BUFFALO ST GLASCO, KS 67445		
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F 000	INITIAL COMMENTS	F 000			
F 600 SS=J	<p>The following citations represent the findings of a Health Resurvey complaint investigation KS#132384 and Extended Health Resurvey.</p> <p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents, of which 1 resident was reviewed for abuse. Based on observation, interview, and record review the facility failed to provide supervision to protect 1 of 1 sampled resident, #15, from resident to resident abuse when Resident #17, made verbal threats toward him/her. Approximately 17 hours later, during a second incident, Resident #17 hit Resident #15 in the mouth, which placed the resident in immediate jeopardy.</p> <p>Findings included:</p>	F 600			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/22/2018

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 600	<p>Continued From page 1</p> <p>- The facility admitted Resident #17 on 9/30/17 and the physician orders documented diagnoses of traumatic head injury (occurs when an external mechanical force causes brain dysfunction), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), hallucinations (sensing things while awake that appear to be real, but the mind created), dementia (progressive mental disorder characterized by failing memory, confusion), and amnesia (loss of memory caused by brain damage or severe emotional trauma).</p> <p>The admission (MDS) Minimum Data Set assessment, dated 10/11/17, documented moderately impaired cognition, other behaviors 4-6 days of the look back period, and daily wandering. The assessment documented the resident was independent with most (ADLs) activities of daily living, had no range of motion impairment, and ambulated without assistive devices. The assessment documented the resident received an antipsychotic (used to treat psychosis and other mental emotional conditions) medication.</p> <p>The 3/30/18 quarterly MDS documented the same except he/she had no behaviors, wandered 1-3 days, required extensive staff assistance with hygiene, and received an antidepressant (used to treat mood disorders and relieve symptoms of depression) medication.</p> <p>The 6/22/18 quarterly MDS documented the same except the resident had delusions (untrue</p>	F 600			

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F 600	<p>Continued From page 2</p> <p>persistent belief or perception held by a person although evidence shows it was untrue).</p> <p>The 12/11/17(CAA) Care Area Assessment summary for behavioral symptoms documented the resident was at risk for impaired social interaction due to dependence on staff for cognitive stimulation and social interaction to maintain a positive psychosocial well-being. The summary documented the resident had chronic confusion related to a head injury, and impaired decision-making skills.</p> <p>The 6/20/18 care plan documented the resident was at risk for decreased activity participation, directed staff to invite the resident to planned activities, and documented the resident liked happy hour, being outdoors, and to "work" on things. The care plan recorded the resident had a history of urinating in the trash can, plants, corner, etc. when he/she was unable to locate a toilet. The care plan directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, TV, or a book. Sometimes he/she just wanted a drink, and beer or mixed drinks which were available for him/her at the facility. The care plan instructed staff to redirect the resident if he/she attempted to wander into other rooms, ensure the Wanderguard alert (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) was in place on his/her wrist, and when conflict occurred, remove the resident to a calm, safe environment.</p> <p>Nursing note (NN) dated 5/17/18 at 8:22 AM, recorded Resident #17 came up behind another resident that was ambulating up the hallway and</p>	F 600			

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F 600	<p>Continued From page 3</p> <p>kicked the back of his/her shoe. Staff separated Resident #17 from the other resident and started (1:1) one to one supervision immediately. While staff talked to Resident #17 and attempted to get him/her to walk to his/her room, he/she hit another resident with his/her open hand. Staff held Resident #17's arm and attempted to stop him/her from swinging, but he/she was still able to make contact. A second staff member was called to assist with the 1:1 and staff took Resident #17 outside for a walk, with both staff members present to walk with him/her.</p> <p>NN on 5/17/18 at 9:24 AM, recorded 2 staff continued 1:1 supervision outside with the resident, and he/she kept saying "that guy killed my dad".</p> <p>NN on 5/17/18 at 3:14 PM, documented the behavioral unit nurse called and notified facility staff they were ready for the resident, so staff drove him/her to the behavioral health unit.</p> <p>On 5/23/18 at 12:40 PM, the (SSD) Social Services Designee documented he/she attended Resident #17's team meeting at the behavioral health unit, and the doctor and staff reported the resident was doing very well, had no behaviors they were concerned about, and the resident was a lot calmer compared to his/her last visit at the unit. The behavioral health unit staff said they were planning to discharge the resident on 5/25/18.</p> <p>NN on 6/29/18 at 11:20 PM, documented this nurse heard a loud noise and inappropriate language and observed Resident #17 walking out of another resident's room. This nurse talked to him/her to see what was going on and tried to</p>	F 600			

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F 600	<p>Continued From page 4</p> <p>redirect Resident #17 to his/her room. Resident #17 followed this nurse to check on the other resident, who was attempting to get off the floor. The belongings of the other resident were thrown on the floor, a wall shelf taken down, and cords to the TV and cable box were ripped out of the wall. This nurse was between the two residents as Resident #17 was upset and stated "he/she stole my ****, why is he/she in here." This nurse assured Resident #17 that this was not his/her room and called down the hall for staff to help with Resident #17. Staff placed the resident on 2 to 1 supervision due to the resident being able to overtake 1 staff member.</p> <p>NN on 8/11/18 at 6:10 PM, documented Resident #17 was combative to other residents and staff. The resident continued to go into other residents' rooms and became angry with staff when they tried to get him/her out. At supper, the resident kept trying to unzip his/her pants to urinate behind the dining room door. Staff intervened, and the resident went down the hall and tried to urinate in the day room.</p> <p>NN on 8/13/18 at 3:12 AM, documented staff heard a resident yelling. When staff entered Resident #15's room, they found Resident #17 standing at the head of the opposite gender resident's bed in his/her underwear. Resident #15 was yelling for Resident #17 to get out of his/her room. When staff tried to redirect Resident #17 out of the resident's room when he/she stated, "I want to just punch that person in [his/her] mouth". Staff asked Resident #15 if Resident #17 touched him/her and he/she stated no, but he/she scared him/her. The note recorded Resident #15's room was next to Resident #17's room and this was not the first time he/she had gone into the resident's</p>	F 600			

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F 600	<p>Continued From page 5</p> <p>room. Resident #17 wandered about the facility for approximately an hour, staff gave him/her something to eat, and he/she returned to his/her room without further incident. (the clinical record lacked evidence staff initiated 1:1 supervision for Resident #17 at this time.)</p> <p>NN on 8/13/18 at 1:40 PM, documented the day shift nurse reported the resident slept most of the morning but was up off and on during the night. The resident was laid in bed with his/her eyes closed.</p> <p>NN on 8/13/18 at 6:30 PM, documented the Office Manager/(CMA) Certified Medication Aide had taken Resident #17 out of the facility for supper. Staff returned the resident to the facility at 6:30 PM and left the resident unattended at the nurse's station drinking a cola.</p> <p>NN on 8/13/18 at 7:55 PM, documented at 7:30 PM, unsupervised by staff, Resident #17 went into Resident #15's room and hit the resident in the mouth, lower left lip. A (CNA) Certified Nurse Aide informed the nurse that he/she found Resident #17 shaking his/her fist at Resident #15, but the CNA could not understand what he/she was saying. The nurse noted blood on Resident #17's right hand knuckles and initiated one-on-one supervision.</p> <p>NN on 8/13/18 at 9:09 PM, documented the nurse called the mental health practitioner, who stated the resident did not need anything at this time. Resident #17 continued to rest in bed with eyes closed, and one on one supervision.</p> <p>NN on 8/14/18 at 5:54 AM, documented the resident continued to rest in bed with his/her eyes</p>	F 600			

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F 600	<p>Continued From page 6 closed, and one on one supervision continued.</p> <p>NN on 8/14/18 at 9:15 AM, documented the resident woke up around 8:00 AM this morning, walked up and down the halls with a nurse aide, and had breakfast in the living room with staff.</p> <p>NN on 8/14/18 at 9:30 AM, documented Resident #17 left the facility with his/her family member who reported he/she would provide lunch to the resident and bring him/her back to the facility this afternoon.</p> <p>NN on 8/14/18 at 2:00 PM, documented Resident #17 returned to the facility and staff informed the family member the resident would be transferred to a behavioral health unit.</p> <p>NN on 8/14/18 at 2:50 PM, documented staff sat outside with the resident, 1 on 1, since he/she arrived back to the facility at 2:00 PM. The resident rested off and on in a chair outside, stayed calm, and carried on small conversation, when initiated by others.</p> <p>NN on 8/14/18 at 3:00 PM, documented staff transferred Resident #17 to the behavioral unit.</p> <p>On 8/14/18 at 8:45 AM, observation revealed Resident #15 sat at a dining table and his/her bottom lip on the left side was swollen and had reddish purple bruising.</p> <p>On 8/14/18 at 3:55 PM, Nurse Aide M stated the resident would have been aggressive with other residents if staff had not intervened. He/she stated the resident was physically and verbally aggressive to staff and he/she had to place himself/herself between Resident #17 and other</p>	F 600			

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F 600	<p>Continued From page 7 residents.</p> <p>On 8/15/18 at 10:23 AM, Nurse Aide Q verified he/she removed the resident from other residents' rooms, and he/she was hesitant, but did not argue or fight.</p> <p>On 8/15/18 at 4:47 PM, Nurse G stated he/she worked the day shift Monday, August 13, 2018, and the 8/12/18 night nurse reported to him/her Resident #17 threatened to "hit an [opposite gender] person in the mouth" but the nurse was not specific who the resident threatened. Nurse G reported Resident #17 had not threatened to hit other residents, just staff, and his/her mood or behavior quickly changed at times. He/she stated if the resident threatened another resident, staff should place Resident #17 on one to one supervision.</p> <p>On 8/16/18 at 7:05 AM, Nurse H stated Resident #17 wandered the halls, set off exit alarms, and staff observed him/her, but did not place him/her under one on one supervision until after the resident hit Resident #15. Nurse H stated the resident sat quietly in the living room with 3 other residents and walked up and down the hall 2-3 times before staff heard Resident #15 hollering for help. Nurse H stated Resident #17 left the room after punching Resident #15. Nurse H stated he/she was unaware that Resident #17 threatened to hit the other resident. Nurse H stated staff has had to remove Resident #17 from Resident #15's room several times. Nurse H stated staff had not informed him/her of the threat or he/she would have had staff provide one on one supervision with Resident #17.</p> <p>8/16/18 at 10:59 AM, Nurse I stated on Sunday</p>	F 600			

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F 600	<p>Continued From page 8</p> <p>night, staff reported Resident #17 threatened to punch someone in the mouth and Nurse I stated Nurse Aide R, who diffused the situation between Residents #17 and #15 early Monday morning, never specified who Resident #17 made that comment toward. Nurse I stated the aide removed him/her from Resident #15's room and gave him/her a sandwich. Nurse I stated all staff watched the resident as much as they could, and he/she did not feel Resident #15 was in any danger of being harmed. Nurse I stated once Resident #17 became fixated on something it was hard to distract him/her, and if someone got into his/her personal space it agitated him/her. Nurse I stated Resident #17 was fast with his/her hands and had hit the staff. He/she wandered at night and went into other residents' rooms. Nurse I stated he/she reported the incident to the next shift nurse.</p> <p>8/16/18 at 1:03 PM, Nurse Aide R stated he/she found Resident #17 in Resident #15's room when he/she was in bed, early Monday morning, 8/13/18, about 3:00 AM. Nurse Aide R stated he/she heard Resident #15 screaming at someone to get out of his/her room and stated he/she found Resident #17, in his/her underwear, standing at the side of the bed about 1 foot away from Resident #15's face. Nurse Aide R stated he/she had trouble redirecting the resident, called for another staff, who was able to get Resident #17 out of Resident #15's room, and Resident #15 reported the other resident had not touched him/her. Nurse Aide R stated Resident #17 looked at him/her (the aide) and said, "I just wanna punch [him/her] in the mouth". Nurse Aide R stated Resident #17's clothes were on the bedside table, which was odd as he/she usually slept in his/her clothes. Nurse Aide R stated</p>	F 600			

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F 600	<p>Continued From page 9</p> <p>he/she reported what Resident #17 said to the nurse, and during the rest of the night staff could not see Resident #17, as the resident closed his/her door.</p> <p>8/16/18 at 1:37 PM, Nurse Aide S stated Monday evening, 8/13/17, he/she heard Resident #15 screaming, he/she responded, found Resident #15's door shut, and when he/she opened the door Resident #15 was in his/her recliner chair with blood dripping from the left side of his/her mouth. Resident #17 was shaking his/her fist, pointing his/her finger at Resident #15, and scolding him/her. Nurse Aide S stated the nurse guided Resident #17 out of room. Resident #15 reported he/she tried to use his/her walker to create space between them and it was on the floor on it's front when I went in. Resident #15 reported Resident #17 hit him/her and said he/she had not done anything to him/her except told him/her to get out of his/her room. Resident #15 was a little on edge the rest of the night, but staff had a person providing one to one supervision with Resident #17 all night.</p> <p>8/16/18 at 2:33 PM, Nurse Aide M stated on Sunday 8/12/18, 3 staff had to remove Resident #17 from Resident #9's room after he/she had grabbed Resident #9's wheelchair in the hallway and pushed him/her. Resident #9 did not like that and became agitated. Nurse Aide M stated he/she asked Resident #17 several times to let go of the wheelchair, but he/she would not let go and pushed the resident into Resident #9's room. Nurse Aide M stated he/she called for help and staff transferred the resident out of the wheelchair and into his/her recliner. Resident #17 went into the resident's bathroom, with staff following, then eventually left the resident's room. Nurse Aide M</p>	F 600			

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F 600	<p>Continued From page 10</p> <p>stated Resident #17 pulled up floor vents and wandered around with them, pulled the hand railing off the wall, pulled the door code boxes off at the doors, wandered in and out of resident rooms, and urinated in their rooms. He/she stated the residents were scared of Resident #17. Nurse Aide M stated on Monday evening 8/13/18, he/she checked on Resident #15 who was holding a wash cloth with ice to his/her lip. Nurse Aide M stated he/she observed blood on the resident's pants and front of his/her shirt, and helped the resident clean up and change since he/she was still shaky. Nurse Aide M stated the resident's mouth had blood in it and asked him/her if his/her teeth were loose, to which he/she replied no. Nurse Aide M stated Resident #15 told him/her when Resident #17 smacked him/her, he/she tried to reach his/her walker and defend himself/herself and that's when Resident #17 kicked him/her. Nurse Aide M stated he/she observed a laceration on the resident's lip, a new bruise on his/her left leg, about 6 inches long and his/her right leg had 2 red spots and a skin tear the size of the end of a thumb, and he/she reported those concerns to the nurse. Nurse Aide M stated Resident #17 tried to hit other residents, but staff intervened.</p> <p>The facility's 11/2016 policy for Preventing Resident Abuse documented the facility's program included the following:</p> <ol style="list-style-type: none"> 1) Training all staff how to resolve conflicts appropriately. 2) Assisting or rotating staff working with difficult or abusive residents. 3) Training staff to understand and manage a resident's verbal or physical aggression. 4) Assessing, care planning, and monitoring residents with needs and behaviors that may lead 	F 600			

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F 600	<p>Continued From page 11 to conflict or neglect.</p> <p>5) Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. involving qualified psychiatrists and other mental health professional to help the staff manage difficult or aggressive residents.</p> <p>6) Striving to maintain adequate staffing on all shifts to ensure the needs of each resident are met and encouraging all staff to report any signs or suspected incidents of abuse to facility management immediately.</p> <p>The facility's undated Protection of Residents During Abuse Investigation documented if the alleged abuse involved another resident, the accused resident's representative and physician would be informed and there may be restrictions placed on the accused resident's ability to visit other residents' rooms unattended. The policy lacked specific interventions such as 1:1 supervision.</p> <p>The facility failed to provide supervision to protect Resident #15 after Resident #17 verbally threatened to "punch that person in the mouth", placing the resident in immediate jeopardy. Approximately 17 hours later, Resident #17 hit Resident #15 in the mouth, causing bleeding and swelling.</p> <p>The facility abated the immediate jeopardy on 8/13/18, when the facility provided one on one supervision for Resident #17. The facility transferred Resident #17 to a behavioral health facility on 8/14/17.</p> <p>The deficient practice remained at a scope and severity of a G.</p>	F 600			

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F 607 SS=D	<p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents of which one was reviewed for behavior. Based on observation, interview, and record review the facility failed to report a threat made by Resident #17 toward another resident to administrative staff in a timely manner.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The facility admitted Resident #17 on 9/30/17 and the physician orders documented diagnoses of traumatic head injury (occurs when an external mechanical force causes brain dysfunction), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), hallucinations (sensing things while awake that appear to be real, but the mind created), dementia (progressive mental 	F 607			

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F 607	<p>Continued From page 13</p> <p>disorder characterized by failing memory, confusion), and amnesia (loss of memory caused by brain damage or severe emotional trauma).</p> <p>The admission (MDS) Minimum Data Set assessment, dated 10/11/17, documented moderately impaired cognition, other behaviors 4-6 days of the look back period, and he/she wandered daily. The assessment documented the resident was independent with most (ADLs) activities of daily living, had no range of motion impairment, and ambulated without assistive devices. The assessment documented no pain, no falls, and the resident received an antipsychotic (used to treat psychosis and other mental emotional conditions) medication.</p> <p>The 3/30/18 quarterly MDS documented the same except no behaviors, wandered 1-3 days, required extensive staff assistance with hygiene, and received an antidepressant (used to treat mood disorders and relieve symptoms of depression) medication.</p> <p>The 6/22/18 quarterly MDS documented the same except the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue).</p> <p>The 12/11/17(CAA) Care Area Assessment summary for behavior documented the resident at risk for impaired social interaction related to being dependent on staff for cognitive stimulation and social interaction to maintain a positive psychosocial well-being. The summary documented the resident had chronic confusion related to a head injury, and impaired decision-making skills.</p>	F 607			

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F 607	<p>Continued From page 14</p> <p>The 6/20/18 care plan documented the resident at risk for decreased activity participation, directed staff to invite the resident to planned activities, and documented the resident liked happy hour, being outdoors, and liked to "work" on things. The care plan recorded the resident had a history of urinating in the trash can, plants, corner, etc. when he/she was unable to locate a toilet. The care plan directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, TV, or a book. Sometimes he/she just wants a drink, and beer or mixed drinks are available for him/her at the facility. The care plan directed staff to redirect the resident if he/she attempted to wander into other rooms, ensure the Wanderguard alert (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) in place on his/her wrist, and when conflict occurred, remove the resident to a calm, safe environment.</p> <p>The resident's progress notes documented the following:</p> <p>On 8/13/18 at 3:12 AM, staff heard a resident yelling and when staff entered Resident #15's room, they found Resident #17 standing at the head of the opposite gender resident's bed in his/her underwear. The resident was yelling for Resident #17 to get out of his/her room, and staff tried to redirect Resident #17 out of the resident's room when he/she stated, "I want to just punch that person in his/her mouth". Staff asked Resident #15 if Resident #17 touched him/her and he/she stated no, but he/she scared him/her. The note recorded Resident #15's room was next to Resident #17's room and this was not the first time he/she had gone into the resident's room.</p>	F 607			

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F 607	<p>Continued From page 15</p> <p>Resident #17 wondered about the facility for approximately an hour, staff gave him/her something to eat, and he/she returned to his/her room without further incident.</p> <p>On 8/13/18 at 1:40 PM, the day shift nurse reported the resident slept most of the morning but was up off and on during the night. The resident was lying in bed with his/her eyes closed.</p> <p>On 8/13/18 at 5:34 PM, Resident #17 left with staff for dinner out of the facility.</p> <p>On 8/13/18 at 6:30 PM, the Office Manager/ (CMA) Certified Medication Aide had taken Resident #17 out of the facility for supper, which he/she seemed to enjoy. Staff returned the resident to the facility at 6:30 PM and left the resident at the nurse's station drinking a cola.</p> <p>On 8/13/18 at 7:55 PM, it was documented at 7:30 PM, Resident #17 went into Resident #15's room and hit the resident in the mouth, lower left lip. A (CNA) Certified Nurse Aide informed the nurse that he/she found Resident #17 shaking his/her fist at Resident #15, but the CNA could not understand what he/she was saying. The nurse noted blood on Resident #17's right hand knuckles and initiated one on one supervision.</p> <p>On 8/13/18 at 9:09 PM, the nurse called the mental health practitioner, who stated the resident did not need anything at this time. Resident #17 continued to rest in bed with eyes closed, and one on one supervision.</p> <p>On 8/14/18 at 2:00 PM, Resident #17 returned to the facility and staff informed the family member the resident would be transferred to a behavioral</p>	F 607			

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F 607	<p>Continued From page 16 health unit.</p> <p>On 8/14/18 at 8:45 AM, observation revealed Resident #15 sat at a dining table and his/her bottom lip on the left side was swollen and had reddish purple bruising.</p> <p>On 8/14/18 at 3:55 PM, Nurse Aide M stated the resident would have been aggressive with other residents if staff had not intervened. He/she stated the resident was physically and verbally aggressive to staff and he/she had to place himself/herself between Resident #17 and other residents.</p> <p>On 8/15/18 at 4:47 PM, Nurse G stated he/she worked the day shift Monday, August 13, 2018, and Resident #17 slept late, got up for a while, laid back down, and had no behaviors during the day shift on Monday. Nurse G stated the 8/12/18 night nurse had reported to him/her Resident #17 had threatened to hit "an opposite gender person in the mouth" but the nurse was not specific who the resident threatened.</p> <p>On 8/16/18 at 7:05 AM, Nurse H stated Resident #17 wandered the halls, set off exit alarms, and staff observed him/her, but did not place him/her under one on one supervision until after the resident hit Resident #15. Nurse H stated on 8/13/18 the resident sat quietly in the living room with 3 other residents and walked up and down the hall 2-3 times before staff heard Resident #15 hollering for help around 7:00 PM. Nurse H stated Resident #17 left the room after punching Resident #15. Nurse H stated he/she was unaware that Resident #17 had threatened to hit the other resident. Nurse H stated staff has had to remove Resident #17 from Resident #15's</p>	F 607			

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F 607	<p>Continued From page 17</p> <p>room several times. Nurse H stated staff had not informed him/her of the threat or he/she would have had staff provide one on one supervision with Resident #17.</p> <p>8/16/18 at 10:59 AM, Nurse I stated staff reported Resident #17 threatened to punch someone in the mouth and Nurse I stated the aide who diffused the situation between Residents #17 and #15 early Monday morning, never specified who Resident #17 made that comment toward. Nurse I stated the aide removed him/her from Resident #15's room and gave him/her a sandwich. Nurse I stated all staff watched the resident as much as they could, and he/she did not feel Resident #15 was in any harm. Nurse I stated once Resident #17 became fixated on something it was hard to distract him/her, and if someone got into his/her personal space it agitated him/her. Nurse I stated Resident #17 was fast with his/her hands, had hit the staff, and wandered at night and went into other resident's rooms. Nurse I stated he/she reported the incident to the next shift nurse.</p> <p>8/16/18 at 1:03 PM, Nurse Aide R stated he/she found Resident #17 in Resident #15's room when he/she was in bed, early Monday morning, 8/13/18, about 3:00 AM. Nurse Aide R stated he/she heard Resident #15 screaming at someone to get out of his/her room and stated he/she found Resident #17, in his/her underwear, standing at the side of the bed about 1 foot away from Resident #15's face. Nurse Aide R stated he/she had trouble redirecting the resident, called for another staff, who was able to get Resident #17 out of Resident #15's room, and Resident #15 reported the other resident had not touched him/her. Nurse Aide R stated Resident #17</p>	F 607			

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F 607	<p>Continued From page 18</p> <p>looked at him/her (the aide) and said, "I just wanna punch him/her in the mouth". Nurse Aide R stated Resident #17's clothes were on the bedside table, which was odd as he/she usually slept in his/her clothes. Nurse Aide R stated he/she reported what Resident #17 said to the nurse, and during the rest of the night staff could not see Resident #17, as the resident closed his/her door.</p> <p>8/16/18 at 1:37 PM, Nurse Aide S stated Monday evening, 8/13/17, he/she heard Resident #15 screaming, he/she responded, found Resident #15's door shut, and when he/she opened the door Resident #15 was in his/her recliner chair with blood dripping from the left side of his/her mouth. Resident #17 was shaking his/her fist, pointing his/her finger at Resident #15, and scolding him/her. Nurse Aide S stated the nurse guided Resident #17 out of room. Resident #15 reported he/she had tried to use his/her walker to create space between them and it was on the floor on its front when I went in. Resident #15 reported Resident #17 hit him/her and said he/she had not done anything to him/her except told him/her to get out of his/her room. Resident #15 was a little on edge the rest of the night, but staff had a person providing one to one supervision with Resident #17 all night.</p> <p>8/16/18 at 2:33 PM, Nurse Aide M stated on Sunday 8/12/18, 3 staff had to remove Resident #17 from Resident #9's room after he/she had grabbed Resident #9's wheelchair in the hallway and pushed him/her. Resident #9 did not like that and became agitated. Nurse Aide M stated he/she asked Resident #17 several times to let</p>	F 607			

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F 607	<p>Continued From page 19</p> <p>go of the wheelchair, but he/she would not let go and pushed the resident into Resident #9's room. Nurse Aide M stated he/she called for help and staff transferred the resident out of the wheelchair and into his/her recliner. Resident #17 went into the resident's bathroom, with staff following, then eventually left the resident's room. Nurse Aide M stated Resident #17 had pulled up floor vents and wandered around with them, pulled the hand railing off the wall, pulled the door code boxes off at the doors, wandered in and out of resident rooms, and had urinated in their rooms. He/she stated the residents were scared of Resident #17. Nurse Aide M stated on Monday evening 8/13/18, he/she checked on Resident #15 who was holding a wash cloth with ice to his/her lip. Nurse Aide M stated he/she observed blood on the resident's pants and front of his/her shirt, and helped the resident clean up and change since he/she was still shaky. Nurse Aide M stated the resident's mouth had blood in it and asked him/her if his/her teeth were loose, to which he/she replied no. Nurse Aide M stated Resident #15 told him/her when Resident #17 smacked him/her, he/she tried to reach his/her walker and defend himself/herself and that's when Resident #17 kicked him/her. Nurse Aide M stated he/she observed a laceration on the resident's lip, a new bruise on his/her left leg, about 6 inches long and his/her right leg had 2 red spots and a skin tear the size of the end of a thumb, and he/she reported those concerns to the nurse. Nurse Aide M stated Resident #17 had tried to hit other residents, but staff intervened.</p> <p>On 8/20/18 at 1127 AM, Administrative Nurse D verified he/she would have expected staff to inform him/her of the verbal threat to "punch that person in the mouth". administrative Staff D</p>	F 607			

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F 607	Continued From page 20 verified Resident #17's behaviors placed the other residents at risk for physical, verbal or mental abuse due to his/her behaviors at times toward the other residents. The facility's 11/2016 policy for Reporting Abuse to Facility Management documented it was the responsibility of staff to promptly report any incident or suspected resident abuse, including verbal, to the administrator or the director of nursing. The facility failed to report a threat made by Resident #17 toward another resident, to administrative staff, in a timely manner and the resident punched the other resident in the mouth within 17 hours of the threat.	F 607			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636			

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F 636	<p>Continued From page 21</p> <p>(v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p>	F 636			

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F 636	<p>Continued From page 22</p> <p>(iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 30 residents. The sample included 12 resident. Based on observation, record review and interview, the facility failed to develop comprehensive care plans for 3 of the 12 sampled residents. Resident #22 for smoking cigarettes, #18 and #23 for diabetic management.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #22's diagnoses included (COPD) chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), schizophrenia (- psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, tobacco use, depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) recurrent with severe psychotic symptoms (major mental disorder characterized by a gross impairment in reality testing) and Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, mask like faces, shuffling gait, muscle rigidity and weakness). <p>The admission (MDS) Minimum Data Set assessment, dated 6/28/18, recorded the resident had intact cognition, no indicators of depression</p>	F 636			

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F 636	<p>Continued From page 23</p> <p>and exhibited no behaviors. The MDS further documented the resident was independent with bed mobility, transfers, dressing, toilet use, personal hygiene, walking in his/her room, locomotion on and off the unit. The resident also received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications.</p> <p>The (CAA) Care Area Assessment, dated 7/3/18, for (ADL) activities of daily living, documented the resident at risk for ADL deficit related to impaired thought processes and mobility secondary to schizophrenia and Parkinson's disease.</p> <p>The 14 day MDS, dated 7/5/18, recorded the resident assessment the same as the admission MDS, and experienced disorganized thinking, delusions, and behavioral symptoms.</p> <p>The care plan, dated 6/22/18, lacked problem, goals, and interventions for smoking.</p> <p>On 7/21/18, a progress note documented the resident would get upset with staff. The resident asked staff to smoke at lunch time, staff informed the resident the staff could not take him/her due to the noon meal time, and the resident responded "well F*** all of you a**holes"</p> <p>On 8/14/18 at 4:17 PM, observation revealed the resident at the nurses station and was upset with staff, because he/she was offered 1 cigarette and he/she wanted 2 cigarettes. The resident in a raised voice stated "I'm going to the big boss" and then the resident walked away. The staff retrieved, 2 cigarettes and took the resident</p>	F 636			

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F 636	Continued From page 24 outside to smoke. On 08/20/18 at 10:10 AM, Administrative Nurse A, verified the resident smoked cigarettes and was not included on the resident's care plan. The facility's Smoking Policy, dated 09/2014, documented any smoking related privileges, restrictions and concerns were noted on the care plan, and all personnel caring for the resident should be alerted to these issues. The facility's Comprehensive Care Plan policy, dated 12/1/15, documented an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial need was developed for each resident. The facility failed to develop any care plan or interventions for this resident identified as a smoker. - This deficient practice also affected Resident #18 and #23's care plans which lacked direction regarding diabetic management.	F 636			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §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	F 688			

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F 688	<p>Continued From page 25</p> <p>§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.</p> <p>§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:</p> <p>The facility had a census of 30 residents. The sample included 12 residents of which 1 was reviewed for positioning. Based on observation, record review and interview, the facility failed to ensure a resident with a limited range of motion received appropriate treatment and services to increase and/or to prevent decrease in range of motion. (#10)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #10's signed physician's orders, dated 8/7/18, documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, epilepsy (brain disorder characterized by repeated seizures) and chronic pain. <p>The quarterly (MDS) Minimum Data Set assessment, dated 6/8/18, documented the resident had short and long term memory problems, severely impaired cognition and required extensive assistance of 2 staff with bed</p>	F 688			

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F 688	<p>Continued From page 26</p> <p>mobility, transfers, dressing and toilet use. The MDS further documented the resident had range of motion impairment with both lower extremities, used a wheelchair and received (PRN) as needed and scheduled pain medications.</p> <p>The 6/11/18 care plan directed 1-2 staff members to assist the resident with major position changes in bed. the care plan recorded the resident had limited range of motion in his/her hips and knees and directed staff to encourage the resident to stretch his/her legs out when lying in the bed.</p> <p>Review of the resident's medical record, lacked documentation staff provided a restorative program to the resident for the last 3 months.</p> <p>On 8/15/18 at 12:32 PM, observation revealed the resident sat in his/her wheelchair with his/her legs drawn up towards his/her chest, and his/her chin approximately 4 inches from chest. Further observation revealed staff assisted the resident to eat his/her meal and did not reposition the resident.</p> <p>On 8/15/18 at 10:19 AM, Therapy Staff GG verified the occupational staff last worked with the resident in 2016.</p> <p>On 8/15/18 at 12:43 PM, Nurse Aide P stated he/she had not been trained to do the restorative program.</p> <p>On 8/16/18 at 10:02 AM, Administrative Nursing staff D verified the resident had not received restorative services and would benefit from stretching exercises so he/she did not become permanently fixed in the fetal position.</p>	F 688			

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F 688	Continued From page 27 The facility's July 2013 Rehabilitative Nursing Care policy documented rehabilitative nursing care was provided for each resident admitted. Rehabilitative nursing care was performed daily for those residents who required such service. Such program included, but was not limited to: maintaining good body alignment and proper positioning, and assisting residents with their routine range of motion exercises. The facility failed to ensure Resident #10, who had a limited range of motion, received appropriate treatment and services to increase and/or to prevent a decrease in range of motion which placed the resident at risk for impaired body alignment.	F 688			
F 692 SS=D	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	F 692			

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F 692	<p>Continued From page 28</p> <p>there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 30 residents. The sample included 12 residents, with one reviewed for nutrition. The facility failed to identify a slow gradual, significant weight loss of 10% in 6 months for 1 sampled resident. (#4)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #4's, signed (POS) Physician Orders Sheet, dated 6/11/18, documented the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, gastro-esophageal reflux disease (back flow of stomach contents to the esophagus), constipation, iron deficiency anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), and vitamin A & B 12 deficiency (a lack of). <p>The annual (MDS) Minimum Data Set assessment, dated 12/8/17, recorded the resident had moderate cognitive impairment, was independent with bed mobility, transfers, walking in the room and corridor, dressing, and toilet use. He/she required set up assistance with eating, had no swallowing disorders, and weighed 121 (lbs.) pounds.</p> <p>The dehydration/fluid maintenance (CAA) Care Area Assessment, dated 12/13/17, recorded the resident was at risk for fluid maintenance less than body requirements related to decreased desire to drink due to dementia.</p>	F 692			

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F 692	<p>Continued From page 29</p> <p>The quarterly MDS, dated 5/18/18, was the same as the 12/8/17 annual assessment, except the resident weighed 112 lbs.</p> <p>The care plan, dated 7/2/18, directed staff to assess the resident's food preferences, and assure his/her dentures were in place. The care plan recorded the resident was on a regular diet, had lactose intolerance, and directed staff to encourage oral intake of foods and fluids, obtain dietary consults, and offer available substitutes if the resident has a problem with the foods being served. The care plan further directed staff provide set up assistance, and weigh the resident monthly.</p> <p>The medical record revealed the following resident weights: 2/2/18 - 119 lbs. 3/8/18 - 116 lbs. 4/4/18 - 114 lbs. 5/1/18 - 113 lbs. 6/6/18 - 110 lbs. 7/6/18 - 110 lbs. 8/7/18 - 108 lbs. 8/14/18 - 106 lbs.</p> <p>On 8/15/17 at 2:07 PM, the resident was weighed, revealing a weight of 106 lbs. resulting in a 10.9% weight loss in 6 months.</p> <p>The dietary note, dated 5/8/18, recorded the resident was on a regular diet with stable weights in the range of 114 - 119 lbs., with no nutritional concerns at that time, and staff would continue to follow and monitor weight status.</p> <p>The 7/16/18 progress note, recorded in a discussion with the dental hygienist, the resident</p>	F 692			

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F 692	<p>Continued From page 30</p> <p>chewed his/her meat then spit it out, no problems with his/her dentures.</p> <p>On 8/14/18 at 8:17 AM, observation revealed the resident sitting in the dining room, and stated he/she was hungry. Direct Care Staff N told the resident, he/she had already eaten. The resident then asked for hot chocolate, and Direct Care Staff N informed the resident that he/she already had 2 cups of hot chocolate, the resident left the dining room, independently.</p> <p>On 8/15/18 at 11:25 AM, Dietary Staff AA, reported the facility has not had a registered dietician for about 3 weeks.</p> <p>On 8/15/18 at 2:46 PM, Administrative Nurse A stated staff were to weight the residents monthly, unless there was a problem, then the residents should be weighed weekly, and monitored by nursing staff. He/she also stated the registered dietician consulting with the facility left the beginning of the month of August. Administrative Nurse A, verified the resident was very active, walked a lot, and ate most anything he/she was offered.</p> <p>The facility's Weight Assessment and Intervention policy, dated 4/2012, stated the dietician would review the unit weight record during scheduled visits to follow individual weight trends over time. Negative trends were evaluated by the dietician whether the criteria for "significant" weight changes had been met. The dietician and multi-disciplinary team would identify conditions and medications that may be causing anorexia, weight loss or increasing the risk or weight loss. The nursing staff and dietician would strive to prevent, monitor and intervene for undesirable</p>	F 692			

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F 692	Continued From page 31 weight loss for the residents. The facility failed to identify gradual weight loss for Resident #4, placing the resident at risk for impaired nutrition.	F 692			
F 730 SS=F	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 had a census of 30 residents. Based on observation, record review and interview, the facility failed to ensure the required 12 hours of in-service training of (CNA) Certified Nursing Aides. Findings included: - Review of the staff in-service training revealed 23 of 23 CNA staff lacked the required 12 hours, which included dementia (a progressive mental disorder characterized by failing memory and confusion) and abuse/neglect/exploitation training. On 8/15/18 at 2:01 PM, Consultant Staff HH verified the facility lacked documentation of abuse/neglect and dementia training for all nurse's aides in the last year and had no system to monitor the mandatory 12 hour training for nurse aides.	F 730			

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F 730	Continued From page 32 The facility's October 2017 In-Service Training Program for Nurse Aides documented all personnel were required to attend regularly scheduled in-service training classes and complete no less than 12 hours of in-services per employment year. The facility failed to ensure the 23 of 23 staff reviewed the required 12 hours of CNA training and failed to develop a system to record and monitor the mandatory training.	F 730			
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: The facility had a census of 30 residents. The sample included 12 residents of which one was reviewed for behavior. Based on observation, interview, and record review the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being for 1 of 1 sampled cognitively impaired resident (#17), who displayed ongoing behaviors and was admitted for inpatient behavioral health care 3	F 740			

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F 740	<p>Continued From page 33 times in the past 3 months.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The facility admitted Resident #17 on 9/30/17 and the physician orders documented diagnoses of traumatic head injury (occurs when an external mechanical force causes brain dysfunction), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), hallucinations (sensing things while awake that appear to be real, but the mind created), dementia (progressive mental disorder characterized by failing memory, confusion), and amnesia (loss of memory caused by brain damage or severe emotional trauma). <p>The admission (MDS) Minimum Data Set assessment, dated 10/11/17, documented moderately impaired cognition, other behaviors 4-6 days of the look back period, and he/she wandered daily. The assessment documented the resident was independent with most (ADLs) activities of daily living, had no range of motion impairment, and ambulated without assistive devices. The assessment documented no pain, no falls, and the resident received an antipsychotic (used to treat psychosis and other mental emotional conditions) medication.</p> <p>The 3/30/18 quarterly MDS documented the same except no behaviors, wandered 1-3 days, required extensive staff assistance with hygiene, and received an antidepressant (used to treat mood disorders and relieve symptoms of</p>	F 740			

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F 740	<p>Continued From page 34 depression) medication.</p> <p>The 6/22/18 quarterly MDS documented the same except the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue).</p> <p>The 12/11/17 (CAA) Care Area Assessment summary for behavior documented the resident at risk for impaired social interaction related to being dependent on staff for cognitive stimulation and social interaction to maintain a positive psychosocial well-being. The summary documented the resident had chronic confusion related to a head injury, and impaired decision-making skills.</p> <p>The 6/20/18 care plan documented the resident at risk for decreased activity participation, directed staff to invite the resident to planned activities, and documented the resident liked happy hour, being outdoors, and liked to "work" on things. The care plan recorded the resident had a history of urinating in the trash can, plants, corner, etc. when he/she was unable to locate a toilet. The care plan directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, TV, or a book. Sometimes he/she just wants a drink, and beer or mixed drinks are available for him/her at the facility. The care plan directed staff to redirect the resident if he/she attempted to wander into other rooms, ensure the Wanderguard alert (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) in place on his/her wrist, and when conflict occurred, remove the resident to a calm, safe environment.</p>	F 740			

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F 740	<p>Continued From page 35</p> <p>The resident's progress notes documented the following:</p> <p>On 5/17/18 at 8:22 AM, Resident #17 came up behind another resident that was ambulating up the hallway and kicked the back of his/her shoe. Resident #17 was separated from the other resident and (1:1) one to one supervision started immediately. While staff talked to Resident #17 and attempted to get him/her to walk to his/her room, he/she hit another resident with his/her open hand. Staff held Resident #17's arm and attempted to stop him/her from swinging, but he/she was still able to make contact. A second staff member was called to assist with the 1:1 and staff took Resident #17 outside for a walk, with both staff members present to walk with him/her. Staff updated the physician, and the geri-psyche unit for possible admission due to the resident's non-provoked aggression.</p> <p>On 5/17/18 at 9:24 AM, 2 staff continued 1:1 outside with the resident, and he/she kept saying "that guy killed my dad". The resident was not aggressive with staff, he/she laughed and joked with staff as usual.</p> <p>On 5/17/18 at 3:14 PM, Resident #17 was happy and joked around, rode to another town with 2 facility staff and got something to eat. Resident #17's family called and asked if the resident could come visit with family and have a beer before they called to admit him/her to the behavioral health facility. Staff stopped at the resident's family home on the way back, for a visit. The behavioral unit nurse called and notified facility staff they were ready for the resident, so staff drove him/her to the behavioral health unit.</p>	F 740			

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F 740	<p>Continued From page 36</p> <p>On 5/23/18 at 12:40 PM, the (SSD) Social Services Designee documented he/she attended Resident #17's team meeting at the behavioral health unit, and the doctor and staff reported the resident was doing very good, had no behaviors they were concerned about, and the resident was a lot calmer compared to his/her last visit at the unit. The behavioral health unit staff said they were planning to discharge the resident on 5/25/18.</p> <p>On 6/29/18 at 11:20 PM, this nurse heard a loud noise and cussing and saw Resident #17 walking out of another resident's room. This nurse talked to him/her to see what was going on and tried to redirect Resident #17 to his/her room. Resident #17 followed this nurse to check on the other resident, who was attempting to get off the floor. The belongings of the other resident were thrown on the floor, a wall shelf taken down, and cords to the TV and cable box were ripped out of the wall. This nurse was between the two residents as Resident #17 was upset and stated "he/she stole my ****, why is he/she in here." This nurse assured Resident #17 that this was not his/her room and hollered down the hall for staff to help with Resident #17. Staff placed the resident on 2 on 1 supervision due to the resident being able to overtake 1 staff member. While attempting to get resident out of the room he/she attempted to "come after" this nurse.</p> <p>On 8/11/18 at 6:10 PM, Resident #17 was combative to other residents and staff. The resident continued to go into other people's rooms and became angry with staff when they tried to get him/her out. At supper, the resident kept trying to unzip his/her pants to urinate behind the dining room door. Staff intervened, and the</p>	F 740			

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F 740	<p>Continued From page 37</p> <p>resident went down the hall and tried to urinate in the day room.</p> <p>On 8/13/18 at 3:12 AM, staff heard a resident yelling and when staff entered Resident #15's room, they found Resident #17 standing at the head of the opposite gender resident's bed in his/her underwear. The resident was yelling for Resident #17 to get out of his/her room, and staff tried to redirect Resident #17 out of the resident's room when he/she stated, "I want to just punch that person in his/her mouth". Staff asked Resident #15 if Resident #17 touched him/her and he/she stated no, but he/she scared him/her. The note recorded Resident #15's room was next to Resident #17's room and this was not the first time he/she had gone into the resident's room. Resident #17 wondered about the facility for approximately an hour, staff gave him/her something to eat, and he/she returned to his/her room without further incident.</p> <p>On 8/13/18 at 1:40 PM, the day shift nurse reported the resident slept most of the morning but was up off and on during the night. The resident was lying in bed with his/her eyes closed.</p> <p>On 8/13/18 at 5:34 PM, Resident #17 left with staff for dinner out of the facility.</p> <p>On 8/13/18 at 6:30 PM, the Office Manager/ (CMA) Certified Medication Aide had taken Resident #17 out of the facility for supper, which he/she seemed to enjoy. Staff returned the resident to the facility at 6:30 PM and left the resident at the nurse's station drinking a cola.</p> <p>On 8/13/18 at 7:55 PM, it was documented at</p>	F 740			

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F 740	<p>Continued From page 38</p> <p>7:30 PM, Resident #17 went into Resident #15's room and hit the resident in the mouth, lower left lip. A (CNA) Certified Nurse Aide informed the nurse that he/she found Resident #17 shaking his/her fist at Resident #15, but the CNA could not understand what he/she was saying. The nurse noted blood on Resident #17's right hand knuckles and initiated one on one supervision.</p> <p>On 8/13/18 at 9:09 PM, the nurse called the mental health practitioner, who stated the resident did not need anything at this time. Resident #17 continued to rest in bed with eyes closed, and one on one supervision.</p> <p>On 8/14/18 at 9:30 AM, Resident #17 left the facility with his/her family member who reported he/she would provide lunch to the resident and bring him/her back to the facility this afternoon.</p> <p>On 8/14/18 at 2:00 PM, Resident #17 returned to the facility and staff informed the family member the resident would be transferred to a behavioral health unit.</p> <p>On 8/14/18 at 3:55 PM, Nurse Aide M stated the resident would have been aggressive with other residents if staff had not intervened. He/she stated the resident was physically and verbally aggressive to staff and he/she had to place himself/herself between Resident #17 and other residents.</p> <p>On 8/15/18 at 10:23 AM, Nurse Aide Q verified he/she had removed the resident from other resident's rooms, and he/she was hesitant, but did not argue or fight.</p> <p>On 8/15/18 at 4:47 PM, Nurse G reported</p>	F 740			

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F 740	<p>Continued From page 39</p> <p>Resident #17 had not threatened to hit other residents, just staff, and his/her mood or behavior quickly changed at times. He/she stated if the resident threatened another resident, staff should place Resident #17 on one to one supervision.</p> <p>On 8/16/18 at 7:05 AM, Nurse H stated Resident #17 wandered the halls, set off exit alarms, and staff observed him/her, but did not place him/her under one on one supervision until after the resident hit Resident #15. Nurse H stated the resident sat quietly in the living room with 3 other residents and walked up and down the hall 2-3 times before staff heard Resident #15 hollering for help. Nurse H stated Resident #17 left the room after punching Resident #15. Nurse H stated he/she was unaware that Resident #17 had threatened to hit the other resident. Nurse H stated staff has had to remove Resident #17 from Resident #15's room several times. Nurse H stated staff had not informed him/her of the threat or he/she would have had staff provide one on one supervision with Resident #17.</p> <p>8/16/18 at 10:59 AM, Nurse I stated on Sunday night, staff reported Resident #17 threatened to punch someone in the mouth and Nurse I stated the aide who diffused the situation between Residents #17 and #15 early Monday morning, never specified who Resident #17 made that comment toward. Nurse I stated the aide removed him/her from Resident #15's room and gave him/her a sandwich. Nurse I stated all staff watched the resident as much as they could, and he/she did not feel Resident #15 was in any harm. Nurse I stated once Resident #17 became fixated on something it was hard to distract him/her, and if someone got into his/her personal space it agitated the resident. Nurse I stated</p>	F 740			

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F 740	<p>Continued From page 40</p> <p>Resident #17 was fast with his/her hands and had hit the staff. He/she wandered at night and went into other resident's rooms.</p> <p>8/16/18 at 1:03 PM, Nurse Aide R stated he/she found Resident #17 in Resident #15's room when he/she was in bed, early Monday morning, 8/13/18, about 3:00 AM. Nurse Aide R stated he/she heard Resident #15 screaming at someone to get out of his/her room and stated he/she found Resident #17, in his/her underwear, standing at the side of the bed about 1 foot away from Resident #15's face. Nurse Aide R stated he/she had trouble redirecting the resident, called for another staff, who was able to get Resident #17 out of Resident #15's room, and Resident #15 reported the other resident had not touched him/her. Nurse Aide R stated Resident #17 looked at him/her (the aide) and said, "I just wanna punch him/her in the mouth". Nurse Aide R stated Resident #17's clothes were on the bedside table, which was odd as he/she usually slept in his/her clothes.</p> <p>8/16/18 at 1:37 PM, Nurse Aide S stated Monday evening, 8/13/17, he/she heard Resident #15 screaming, he/she responded, found Resident #15's door shut, and when he/she opened the door Resident #15 was in his/her recliner chair with blood dripping from the left side of his/her mouth. Resident #17 was shaking his/her fist, pointing his/her finger at Resident #15, and scolding him/her.</p> <p>8/16/18 at 2:33 PM, Nurse Aide M stated on Sunday 8/12/18, 3 staff had to remove Resident #17 from Resident #9's room after he/she had grabbed Resident #9's wheelchair in the hallway</p>	F 740			

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F 740	Continued From page 41 and pushed him/her. Resident #9 did not like that and became agitated. Nurse Aide M stated he/she asked Resident #17 several times to let go of the wheelchair, but he/she would not let go and pushed the resident into Resident #9's room. Nurse Aide M stated he/she called for help and staff transferred the resident out of the wheelchair and into his/her recliner. Resident #17 went into the resident's bathroom, with staff following, then eventually left the resident's room. Nurse Aide M stated Resident #17 had pulled up floor vents and wandered around with them, pulled the hand railing off the wall, pulled the door code boxes off at the doors, wandered in and out of resident rooms, and had urinated in their rooms. He/she stated the residents were scared of Resident #17. Nurse Aide M stated on Monday evening 8/13/18, he/she checked on Resident #15 who was holding a wash cloth with ice to his/her lip. Nurse Aide M stated he/she observed blood on the resident's pants and front of his/her shirt, and helped the resident clean up and change since he/she was still shaky. Nurse Aide M stated the resident's mouth had blood in it and asked him/her if his/her teeth were loose, to which he/she replied no. Nurse Aide M stated Resident #15 told him/her when Resident #17 smacked him/her, he/she tried to reach his/her walker and defend himself/herself and that's when Resident #17 kicked him/her. Nurse Aide M stated he/she observed a laceration on the resident's lip, a new bruise on his/her left leg, about 6 inches long and his/her right leg had 2 red spots and a skin tear the size of the end of a thumb, and he/she reported those concerns to the nurse. Nurse Aide M stated Resident #17 had tried to hit other residents, but staff intervened. On 8/20/18 at 11:03 AM, Social Services Staff P	F 740			

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F 740	<p>Continued From page 42</p> <p>stated the resident received mental health services from an outside source every 2 months and he/she had not observed any changes in the resident's behavior after his/her visits. Social Services Staff P stated after the resident's last visit to a behavioral health unit, he/she was harder to re-direct, more restless, and changed in his/her ability to focus on tasks. Social Services Staff P verified Resident #17's behaviors placed the other residents at risk for physical and verbal abuse.</p> <p>On 8/20/18 at 11:27 AM, Administrative Nurse D verified he/she would have expected staff to inform administrative staff of the verbal threat to "punch that person in the mouth". Administrative Nurse D verified Resident #17's behaviors placed the other residents at risk for physical, verbal or mental abuse due to his/her behaviors at times toward the other residents.</p> <p>Upon request the facility failed to provide a policy regarding resident behavior.</p> <p>The facility's 11/2016 policy for Preventing Resident Abuse documented the facility's program included the following: training all staff how to resolve conflicts appropriately. training staff to understand and manage a resident's verbal or physical aggression. assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect. assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. involving qualified psychiatrists and other mental health professional to help the staff</p>	F 740			

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F 740	Continued From page 43 manage difficult or aggressive residents. The facility failed to provide effective behavioral health interventions to attain or maintain the highest practicable mental and psychosocial well-being for 1 of 1 sampled resident (#17), who displayed ongoing behaviors towards other residents and staff and was admitted for inpatient behavioral health care 3 times in the past 3 months.	F 740			
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756			

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F 756	<p>Continued From page 44</p> <p>action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 30 residents. The sample included 12 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility's consultant pharmacist failed to identify and report to the director of nursing and the physician, the lack of adequate monitoring of fingerstick blood sugar readings for 1 of 5 sampled residents (#18), failure to notify the physician of blood pressures outside of parameters (#23) and adequate monitoring of bowel movements for 4 of 5 sampled residents (#2, #18, #23, #28).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The signed physician's orders for Resident #18, dated 8/7/18, documented diagnoses of chronic pain, constipation, and Type 2 Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with hyperglycemia (greater than normal amount of glucose in the blood). <p>Resident #18's quarterly (MDS) Minimum Data</p>	F 756			

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F 756	<p>Continued From page 45</p> <p>Set assessment, dated 6/22/18, documented the resident had severely impaired cognition with a (BIMS) Brief Interview for Mental Status score of 3, and required extensive assistance of 1 staff with transfers, dressing, toilet use, and bathing. The MDS recorded the resident used a walker and wheelchair, was always continent of bowel, received (PRN), as needed, and scheduled pain medications.</p> <p>The 10/20/17 annual MDS (CAA) Care Area Assessment for nutrition documented the resident was at risk for imbalanced nutrition more than body requirements related to frequent snacking and decreased activity.</p> <p>The 6/25/18 care plan directed staff to observe for side effects of pain medication such as constipation, complete daily bowel tracking and provide medication per order, but lacked direction to the staff regarding the resident's diabetes.</p> <p>The 5/3/18 physician's orders directed staff to check Resident #18's blood sugar four times a day related to Type 2 Diabetes Mellitus with hyperglycemia.</p> <p>The 8/7/18 physician's orders directed staff to administer the following medications: Norco (narcotic pain medication) 5-325 (mg) milligrams, orally, twice a day, and, every 4 hours, PRN for pain, initiated 6/14/18. Miralax powder (laxative - a medication to induce bowel movements), 17 grams, orally, PRN, for constipation, initiated 5/3/18. Milk of Magnesia (laxative), 1,200 mg/15 (ml) milliliters, 30 ml, orally, PRN, for constipation every 3rd day, initiated 5/1/18. Bisacodyl (laxative) tablet, 5 mg, orally, PRN, for</p>	F 756			

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F 756	<p>Continued From page 46</p> <p>constipation, every 3rd day, initiated 5/1/18. Bisacodyl suppository, 10 mg, insert rectally, every 4 hours, PRN, for constipation, initiated 5/1/18.</p> <p>The medication administration record, from July 23 - August 14, 2018, revealed from 1-3 missing daily entries of the four times a day fingerstick blood sugar readings.</p> <p>Review of the resident's (BM) Bowel Movement records for May 2018, revealed the resident had no BM for 7 days, from 5/2 -5/8/18 and for 6 days, from 5/14 - 5/19/18. The medical record revealed no documentation a bowel assessment or intervention was completed during the days without a BM.</p> <p>Review of the resident's BM records for June 2018, revealed the resident had no BM for 14 days, from 6/5 - 6/18/18. The medication administration record for June 2018, revealed a Bisacodyl tablet was administered on 6/11/18 (7th day with no BM) and was ineffective.</p> <p>Review of the resident's BM records, for July 2018, revealed the resident had no BM for 7 days, from 7/22 - 7/28/18. The medical record revealed no documentation a bowel assessment or intervention was completed during the days without a BM.</p> <p>Review of the 5/22/18, 6/26/18, and 7/31/18 pharmacy consultant reviews revealed no documentation regarding the lack of documentation of daily fingerstick blood sugars and the lack of bowel movement monitoring for May, June and July for Resident #18.</p>	F 756			

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F 756	<p>Continued From page 47</p> <p>On 8/14/18 at 12:34 PM, observation revealed the resident seated in a wheelchair and propelled himself/herself in the hallway.</p> <p>On 8/15/18 at 10:03 AM, Administrative Nurse D verified the staff were to check the resident's fingerstick blood sugar four times a day and the documentation was missing numerous daily entries from 7/23/18 to 8/14/18.</p> <p>On 8/15/18 at 1:30 PM, Administrative Nurse D verified the resident's medical record lacked bowel movement documentation numerous times in May, June and July 2018, and reported if a resident had not had a bowel movement for 3 days, he/she would expect staff to administer Milk of Magnesia and the next shift should follow up with the resident. Administrative Nurse D stated if the resident still had not had a bowel movement, the staff should try something different, and if no bowel movement the next day, staff should notify the physician.</p> <p>On 8/15/18 at 2:26 PM, Nurse G reported staff print a daily list of residents who have not had a bowel movement in 3 days, staff administer Milk of Magnesia or prune juice to the resident and the nurse aides document the resident's bowel movements in the computer.</p> <p>On 8/16/18 at 8:38 AM, Nurse Aide O reported staff document the resident's bowel movements in the computer and at times, forget to chart the bowel movements.</p> <p>On 8/16/18 at 10:04 AM, Administrative Nurse E verified the consultant pharmacist had not addressed the lack of documentation of the daily fingerstick blood sugars and the lack of bowel</p>	F 756			

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F 756	<p>Continued From page 48</p> <p>movement monitoring for May, June and July for Resident #18.</p> <p>The facility's undated Blood Glucose Monitoring policy documented staff would follow general documentation guidelines and document date, time, and blood glucose testing results.</p> <p>The facility's undated standing orders documented staff would administer laxatives: Milk of Magnesia, 30 (cc) cubic centimeters, orally, PRN, every 3rd day for constipation; Dulcolax suppository, 10 mg, rectally, PRN, every 3rd day for constipation or Bisacodyl, 5 mg, 1 tablet, orally, every 3rd day for constipation.</p> <p>The facility's April 2014 Role of Pharmaceutical Services policy documented a summary of the monthly review of each resident's drug regiment, including irregularities, and an update on previously noted irregularities would be completed by the consultant pharmacist.</p> <p>The facility's consultant pharmacist failed to identify and report to the director of nursing and the physician the facility's failure to adequately monitor fingerstick blood sugar readings and bowel movements for Resident #18, placing the resident at risk for impaired health.</p> <p>- This deficient practice also affected Resident #23, who had blood pressures outside of parameters and did not notify the physician, and periods of 4 to 7 days without bowel movements, and no interventions were documented. The facility's consultant pharmacist failed to identify and report to the director of nursing and the physician these irregularities.</p>	F 756			

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F 756	Continued From page 49 - This deficient practice also affected Resident #2, who had periods of 5 to 9 days without bowel movements and no interventions were documented. - This deficient practice also affected Resident #28, who had a period of 18 days without bowel movements and no interventions were documented. The facility's consultant pharmacist failed to identify and report to the director of nursing and the physician these irregularities.	F 756			
F 757 SS=E	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 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:	F 757			

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F 757	<p>Continued From page 50</p> <p>The facility had a census of 30 residents. The sample included 12 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to adequately monitor fingerstick blood sugar readings for 1 of 5 sampled residents (#18), failed to notify the physician of blood pressures outside of parameters (#23) and adequately monitor bowel movements for 4 of 5 sampled residents (#2, #18, #23, #28).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The signed physician's orders for Resident #18, dated 8/7/18, documented diagnoses of chronic pain, constipation (difficulty passing stools), and Type 2 Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with hyperglycemia (greater than normal amount of glucose in the blood). <p>The quarterly (MDS) Minimum Data Set assessment, dated 6/22/18, documented the resident had severely impaired cognition with a (BIMS) Brief Interview for Mental Status score of 3, and required extensive assistance of 1 staff with transfers, dressing, toilet use, and bathing. The MDS recorded the resident was always continent of bowel, received (PRN), as needed, and scheduled pain medications.</p> <p>The 10/20/17 annual MDS (CAA) Care Area Assessment for nutrition documented the resident was at risk for imbalanced nutrition more than body requirements related to frequent snacking and decreased activity.</p> <p>The 6/25/18 care plan directed staff to observe</p>	F 757			

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F 757	<p>Continued From page 51</p> <p>for side effects of pain medication such as constipation, complete daily bowel tracking and provide medication per physician order, but lacked direction to the staff regarding monitoring the resident's diabetes.</p> <p>The 5/3/18 physician's orders directed staff to check Resident #18's blood sugar four times a day related to Type 2 Diabetes Mellitus with hyperglycemia.</p> <p>The 8/7/18 physician's orders directed staff to administer the following medications: Norco (narcotic pain medication) 5-325 (mg) milligrams, orally, twice a day, and, every 4 hours, PRN for pain, initiated 6/14/18. Miralax powder (laxative - a medication to induce bowel movements), 17 grams, orally, PRN, for constipation, initiated 5/3/18. Milk of Magnesia (laxative), 1,200 mg/15 (ml) milliliters, 30 ml, orally, PRN, for constipation every 3rd day, initiated 5/1/18. Bisacodyl (laxative) tablet, 5 mg, orally, PRN, for constipation, every 3rd day, initiated 5/1/18. Bisacodyl suppository, 10 mg, insert rectally, every 4 hours, PRN, for constipation, initiated 5/1/18.</p> <p>Of the four times a day fingerstick blood sugar readings between July 23 - August 14, 2018, the medication administration record revealed 1-3 missing entries each day.</p> <p>Review of the resident's (BM) Bowel Movement records for May 2018, lacked evidence the resident had a BM for 7 days, from 5/2 -5/8/18 and for 6 days, from 5/14 - 5/19/18. The medical record lacked evidence of documentation for a bowel assessment or interventions completed</p>	F 757			

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F 757	<p>Continued From page 52 during the days without a BM.</p> <p>Review of the resident's BM records for June 2018, lacked evidence the resident had a BM for 14 days, from 6/5 - 6/18/18. The medication administration record for June 2018, revealed a Bisacodyl tablet was administered on 6/11/18 (7th day with no BM) and was ineffective and the record lacked evidence of further follow up.</p> <p>Review of the resident's BM records, for July 2018, lacked evidence the resident had a BM for 7 days, from 7/22 - 7/28/18. The medical record lacked evidence staff completed a bowel assessment or interventions completed during the days without a BM.</p> <p>On 8/14/18 at 12:34 PM, observation revealed the resident seated in a wheelchair and propelled himself/herself in the hallway.</p> <p>On 8/15/18 at 10:03 AM, Administrative Nurse D verified the staff were to check the resident's fingerstick blood sugar four times a day and confirmed the record lacked documentation for numerous daily entries from 7/23/18 to 8/14/18.</p> <p>On 8/15/18 at 1:30 PM, Administrative Nurse D verified the resident's medical record lacked bowel movement documentation numerous times in May, June and July 2018. Staff D reported when a resident had not had a bowel movement for 3 days, he/she would expect staff to administer Milk of Magnesia and the next shift should follow up with the resident. Administrative Nurse D stated if the resident still had not had a bowel movement, the staff should try another PRN ordered medication, and if no bowel movement the next day, staff should notify the</p>	F 757			

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F 757	<p>Continued From page 53 physician.</p> <p>On 8/15/18 at 2:26 PM, Nurse G reported staff printed a daily list of residents who have not had a bowel movement in 3 days. Staff administer Milk of Magnesia or prune juice to the resident and the nurse aides document results of the resident's bowel movements in the computer.</p> <p>On 8/16/18 at 8:38 AM, Nurse Aide O reported staff documented the resident's bowel movements in the computer and at times, forget to chart the bowel movements.</p> <p>The facility's undated Blood Glucose Monitoring policy documented staff would follow general documentation guidelines and record the date, time, and blood glucose testing results.</p> <p>The facility's undated standing orders documented staff would administer laxatives: Milk of Magnesia, 30 (cc) cubic centimeters, orally, PRN, every 3rd day for constipation; Dulcolax suppository, 10 mg, rectally, PRN, every 3rd day for constipation or Bisacodyl, 5 mg, 1 tablet, orally, every 3rd day for constipation.</p> <p>The facility failed to adequately monitor fingerstick blood sugar readings as ordered and failed to monitor for constipation and bowel movements for Resident #18.</p> <p>- This deficient practice also affected Resident #23, who had blood pressures outside of parameters, the facility did not notify the physician, and periods of 4 days and 7 days without bowel movements and no interventions were documented.</p>	F 757			

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F 757	Continued From page 54 - This deficient practice also affected Resident #2, who had periods of 5 days and 9 days without bowel movements and no interventions were documented. - This deficient practice also affected Resident #28, who had a period of 18 days without bowel movements and no interventions were documented.	F 757			
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition	F 801			

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F 801	<p>Continued From page 55</p> <p>professional.</p> <p>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.</p> <p>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.</p> <p>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-</p> <p>(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:</p> <p>(A) A certified dietary manager; or</p> <p>(B) A certified food service manager; or</p> <p>(C) Has similar national certification for food service management and safety from a national certifying body; or</p> <p>(D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and</p> <p>(ii) In States that have established standards for food service managers or dietary managers,</p>	F 801			

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F 801	<p>Continued From page 56</p> <p>meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 30 residents. The sample included 12 residents. Based on observation and interview, the facility failed to employ a full time certified dietary manager to prepare meals for the 30 residents who reside in the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 8/13/18 at 3:55 PM, during initial tour of the kitchen and preparation of the evening meal, Dietary Staff AA identified himself/herself as the Dietary Manager, stated he/she was not certified, and was currently enrolled in the certification class. <p>On 8/14/18 at 10:41 AM, observation revealed Dietary Staff AA followed the recipe correctly, and prepared the pureed foods for one resident.</p> <p>On 8/14/18 at 10:36 AM, Dietary Staff AA stated the residents who are were on a mechanical soft diet received a pureed diet. Dietary Staff AA stated he/she knew it was not correct, but a lot of the kitchen staff did not know how to prepare a mechanical soft diet, so staff made a pureed diet instead.</p> <p>The facility's Food Services Manager policy, dated December 2008, documented the Food</p>	F 801			

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F 801	Continued From page 57 Services Manager should be a qualified supervisor licensed by this state and was knowledgeable and trained in food procurement storage, handling, preparation, and delivery.	F 801			
F 812 SS=F	The facility failed to employ a full time certified dietary manger to supervise and prepare meals for all the residents who received meals from the facility kitchen, placing the residents at risk for lack of adequate nutrition and assessments. 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 had a census of 30 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute and	F 812			

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F 812	<p>Continued From page 58</p> <p>serve food in safe and sanitary conditions.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 8/13/18 at 3:55 PM, during initial tour of the kitchen, observation revealed the main kitchen floor was very sticky with dried on food items. <p>On 8/14/18 at 10:05 AM, observation revealed the following:</p> <ul style="list-style-type: none"> the kitchen floor remained sticky and discolored, the coffee maker with calcium buildup where water is poured into the machine the dishwasher with calcium buildup across the top of the machine the hand washing sink with rust around the hot water handle and down into the sink approximately 2 inches wide extending from the top of the sink down to the drain the exit door from the kitchen to the dining room with paint missing around the door handle and lock, missing paint approximately 2 feet up from the base of the door, 6 inches long, and 1/4 inch wide <p>On 8/14/18 at 10:34 AM, observation revealed Dietary Staff BB walking around the kitchen without a hair net on while food was being prepared</p> <p>On 8/14/18 at 10:41 AM, observation revealed Dietary Staff AA prepared the pureed foods. Observation revealed Dietary Staff AA, wore gloves, obtained a large can of spinach, placed 3, 4 ounce servings of spinach into the blender, pureed the spinach, and placed it in 3 small serving bowls. Continued observation revealed</p>	F 812			

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F 812	<p>Continued From page 59</p> <p>Dietary Staff AA proceeded to move a pan of brownies, obtained clean plastic containers out of the cabinet, placed an item into the trash can, and touched the trash can lid. Continued observation revealed Dietary Staff AA, wore the same soiled gloves, went over to the counter, placed the unused spinach into the clean plastic containers, placed the lids on each container, went to the stove and stirred the meat browning in the frying pan.</p> <p>On 8/14/18 at 10:45 AM, continued observation revealed Dietary Staff AA placed the pureed bowls of spinach into the microwave, obtained 8 clean bowls, dished out spinach from one of the plastic containers for the mechanical soft diet and placed in a bowl, obtained a clean dry washrag, made it wet with water, wiped off the counter where spinach had spilled, obtained a knife and cut the pan of brownies, all while wearing the same soiled gloves.</p> <p>On 8/14/18 at 10:48 AM, Dietary Staff AA verified he/she had not changed his/her soiled gloves, Dietary Staff AA removed the soiled gloves, obtained new gloves, started to put them on, then realized he/she had not washed his/her hands. Dietary Staff AA proceeded to wash his/her hands, then put on clean gloves.</p> <p>On 8/14/18 at 11:05, observation revealed Dietary Staff BB worked in the kitchen not wearing a hair net, obtained brownies out of the pan and placed them on individual plates. When he/she was finished dishing out the brownies, Dietary Staff BB verified he/she should wear a hair net.</p> <p>On 8/14/18 at 10:36 AM, Dietary Staff AA stated the residents who were on a mechanical soft diet</p>	F 812			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2018
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F 812	Continued From page 60 received a pureed diet. Dietary Staff AA stated he/she knew it was not correct, but a lot of the kitchen staff did not know how to prepare a mechanical soft diet, so they made a pureed diet instead. On 8/15/18 at 11:25 AM, Dietary Staff AA stated the facility had not had a Registered Dietician for about 3 weeks, and the nurses monitored the resident's weights and wounds. The facility's Food Preparation and Service policy, dated October 2017, documented food preparation staff should adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness. Bare hand contact with food was prohibited. Gloves must be worn when handling food directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks. Disposable gloves are single-use items and should be discarded after each use. Food and nutrition services staff should wear hair restraints (hair net, hat, beard restraint, etc.) so that hair would not contact food. The facility's Maintenance Service policy, dated December 2009, documented functions of maintenance personnel include, but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, and maintaining the building in good repair and free from hazards. The facility failed to store, prepare, distribute and serve food in safe and sanitary conditions in 1 of 1 kitchen, placing the residents at risk for food borne illnesses.	F 812			
F 921	Safe/Functional/Sanitary/Comfortable Environ	F 921			

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F 921 SS=E	Continued From page 61 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 had a census of 30 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to provide a safe environment for 4 cognitively impaired independently mobile residents. Findings Included: - On 8/13/18 at 4:00 PM, during initial tour, on the west hallway, the door to the whirlpool/bath room was unlocked. Inside the room, next to the whirlpool tub, seated on the floor, a Betco AF 315, 32 (oz.) ounce container of disinfectant which was ½ full and a Hibiclens skin cleanser, gallon size container which contained ¼ of the cleanser. The cabinet next to the whirlpool tub contained 5 disposable razors, and on the edge of the sink was a 4 oz. spray can of Cotton Blossom air freshener. All containers had warning label which stated to "keep out of reach of children". On 8/13/18 at 4:10 PM, Nurse J, verified the door to the whirlpool/bathing room should have been locked, contained items that would harm residents and the label instructions stated, keep out of reach of children. Staff Nurse J also verified Resident #4, who was wandering the hall and opening the closed doors to resident rooms, at the time of initial tour, was confused.	F 921			

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F 921	<p>Continued From page 62</p> <p>On 8/13/18 at 4:11 PM, during initial tour, observations further revealed an unlocked drawer behind the open nurse's station with 2 pair of scissors and unlocked area under the sink area with 2 full containers of Clorox wipes, 1 lb 3.7 oz, 1 full container of WD-40 14.40 oz, 1 full bottle and 1/2 full bottle of Arm & Hammer Carpet Cleaner 64 fluid oz, 1/4 full spray bottle Betco Ocean Breeze 32 oz, 1/2 full bottle Betco deep blue glass surface cleaner 32 oz, and 1 full can Raid flying insect spray 18 oz.</p> <p>On 8/16/18 at 10:04 AM, Nurse A, verified the facility had 4 cognitively impaired independently mobile residents and the chemicals and scissors should be locked up.</p> <p>The 12/2009 facility Storage Areas, Maintenance/Housekeeping policy recorded cleaning supplies labeled "keep out of reach of children" would not be left unattended in a resident room or other area accessible to residents.</p> <p>The facility's Safety and Supervision of Residents policy, dated December 2008, documented the facility-oriented and resident-oriented approaches to safety were used together to implement a systems approach to safety, which considered the hazards identified in the environment and individual resident risk factors, and then adjusted interventions accordingly.</p> <p>The facility's General Safety Precautions, dated December 2009, documented the personnel would not leave work areas unattended where supplies or equipment were being used.</p> <p>The facility failed to provide a safe, hazard free</p>	F 921			

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F 921	Continued From page 63 environment for 4 cognitively impaired independently mobile residents, which placed the residents at risk for accidents.	F 921			