

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

PRINTED: 02/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - PIKE CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5651 LIMESTONE ROAD WILMINGTON, DE 19808</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual and complaint visit was conducted at this facility from October 8, 2015 through October 22, 2015. The deficiencies contained in this report are based on observations, interviews, review of the residents' clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 156. The Stage 2 survey sample size was 47.</p> <p>Abbreviations/definitions used in this 2567 are as follows:  NHA - Nursing Home Administrator;  DON - Director of Nursing;  ADON - Assistant Director of Nursing;  NP - Nurse Practitioner;  RNAC - Registered Nurse Assessment Coordinator;  DCD - Director of Care Delivery;  RN - Registered Nurse;  LPN - Licensed Practical Nurse;  RD - Registered Dietician;  CNA - Certified Nurse's Aide;  SD/IC - Staff Development/Infection Control;  SS - Social Services;  FSD - Food Service Director;  FMD - Facility Maintenance Director;  Acute - sudden onset;  ADL/activities of daily living - bathing, eating, toileting and hygiene;  Anticoagulant - blood thinning medication;  Antimicrobial rinse - mouthwash that acts directly on oral bacteria to help reduce plaque;  Bacteremia - presence of bacteria in the bloodstream, may result from ordinary activities (such as vigorous tooth brushing) or from infections (such as pneumonia or a urinary tract</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/27/2015

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

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F 000	Continued From page 1 infection); CAA/Care Area Summary - part of MDS assessment which assists in identifying and planning for potential problem care areas; Chronic - persisting for a long time or constantly returning; CMS- Centers for Medicare & Medicaid Services; C/o - complained of; Coccyx- tailbone; Cognitive - of or pertaining to the mental processes of memory, judgment, and reasoning; Cognitively intact - able to make own decisions; Comfort care - care that helps or soothes a person who is dying; Continent/continence - full control of bladder and/or bowel function; COTA - Certified Occupational Therapy Assistant; C&S/Culture and Sensitivity - laboratory test to identify which bacteria is causing the infection and which antibiotic will kill the bacteria; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; DM/diabetes mellitus - disease where blood sugar levels are too high; Diuretics - medicines that help reduce the amount of water/excess fluid in the body; DVT/Deep Vein Thrombosis - occurs when a blood clot (thrombus) forms in one or more of the deep veins in your body, usually in your legs; Dx - diagnosis; ED - Emergency Department; eMAR - electronic Medication Administration Record; E. coli/Escherichia coli - bacteria found in	F 000		
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F 000	Continued From page 2 infection of the urinary tract; eTAR - electronic Treatment Administration Record; Extensive assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; Frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; gen. - generalized; H&P - History and Physical; HS/hs - hour of sleep/bedtime; Humalog insulin - injected within fifteen minutes before eating or right after eating a meal; Hoyer lift - sling-type hydraulic lift; Idiopathic peripheral autonomic neuropathy - autonomic neuropathy occurs when the nerves that control involuntary bodily functions are damaged; may affect blood pressure, temperature control, digestion, and bladder function; nerve damage interferes with the messages sent between the brain and other organs and areas of the autonomic nervous system, such as the heart, blood vessels and sweat glands; Diabetes is generally the most common cause of autonomic neuropathy; incontinent/incontinence-loss of control of bladder and/or bowel function; INR- international normalized ratio; used to monitor the effectiveness of anticoagulant medications such as Warfarin or Coumadin; IBS/Irritable bowel syndrome - group of symptoms including pain or discomfort in your abdomen and changes in your bowel movement patterns that occur together; Kardex - care card used for CNAs which	F 000		

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F 000	Continued From page 3 identifies resident's care needs; lb./lbs. - pound/pounds; Lethargy - sluggish, drowsy, unenergetic; Macular Degeneration - leading cause of severe vision loss in people over age 60. Occurs when the small central portion of the retina, known as the macula, deteriorates; MAR/Medication Administration Record - list of resident's daily medications to be administered; MASD/Moisture Associated Skin Damage - general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus; MDRO/multi-drug resistant organisms - common bacteria (germs) that have developed resistance to multiple types of antibiotics; MDS/Minimum Data Set - standardized assessment form used in nursing homes; Metastatic cancer - cancer that has spread from the place where it first started to another place in the body; mg - milligram; ml - milliliter/one (1) ounce is equal to 30 ml; mod. - moderate; MRSA/Methicillin-resistant Staphylococcus aureus - bacterium which is resistant to antibiotics, and that causes infections in different parts of the body, including the urinary tract; NN's - nurses notes; Occasionally incontinent - less than 7 episodes of urine incontinence; Organisms - various types of bacteria; oz - ounces; Palliation - to relieve or lessen without curing; Parkinson's Disease - progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking ( tremors) and difficulty with walking, movement,	F 000		

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F 000	Continued From page 4 and coordination; Plaque - a soft, sticky film that builds up on teeth and contains millions of bacteria that cause tooth decay and gum disease if not removed regularly through brushing and flossing; PO/po - by mouth; POS/Physician Order Sheet - monthly report of resident's active physician orders; Pressure ulcer - sore area of skin that develops when the blood supply to it is cut off due to pressure; PRN/prn - as needed; Prog/Prognosis - probable course and outcome of a disease; Pt/pt - patient; PT - Physical Therapist; Q/q - every; RAI/Resident Assessment Instrument - used to facilitate accurate and effective resident assessment in long-term care facilities; Sepsis - blood infection; Septicemia - bacteria circulating in the blood that multiply and produce toxins that make a person seriously ill with chills, fever, nausea, diarrhea, headache, and possible loss of consciousness; Sliding scale with insulin coverage - dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher; Somnolence - state of strong desire for sleep, or sleeping for unusually long periods; Standing/routine order - medication administered regularly instead of when needed (prn); Subcutaneously- injection given into the fat layer between the skin and the muscle; Trochanter - part of the thighbone connecting to the hip bone; UA/urinalysis - laboratory testing of urine;	F 000		

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F 000	Continued From page 5 UTI/Urinary Tract Infection - bacteria in the urine; Voiding diary - a record of voiding (urinating) for 3 days; 4 x 4 - four by four in gauze pad; 24 hour chart check - night shift (11 PM - 7 AM) reviews orders written in the preceding 24 hours to verify accuracy; & - and; > - greater than.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/ DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		12/31/15	

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F 157	<p>Continued From page 6</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview, it was determined that the facility failed to notify R374's physician/NP when the resident had a INR result of 4.0 on 7/2/15 with potential for requiring physician/NP intervention for one (R374) out of 47 Stage 2 sampled residents. Findings include:</p> <p>R374 was admitted to the facility on 6/12/15 on Coumadin (anticoagulant medication).</p> <p>Review of R374's care plan for anticoagulant therapy, dated 6/15/15, listed a goal of "Will maintain lab (laboratory) values in therapeutic range" and interventions included "... Obtain Labs as ordered and notify physician of results..."</p> <p>R374 had physician orders written for Coumadin and to hold for INR &gt; 3.0 on 6/12/15, 6/22/15 and 6/29/15.</p> <p>Review of NN's dated 7/2/15 revealed that R374 was seen by E21 (NP) at 12:31 PM.</p> <p>Review of a 7/2/15 INR result of 4.0 was reported to the facility at 3:18 PM. It was initialed by E20 ( NP) on 7/6/15 indicating that E20 was aware of the result on 7/6/15.</p> <p>There were no NN's indicating that a physician or NP was notified of R374's 4.0 INR result on 7/2/ 15.</p>	F 157	<p>It is the practice of the facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).</p> <p>Resident R374 no longer resides in the facility.</p> <p>The Administrative Director of Nursing Services (ADNS) and or Designee will audit the medical record of residents that are on Coumadin to identify if INR is out of therapeutic range and if physician or nurse practitioner were notified.</p>	

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F 157	Continued From page 7  The facility failed to notify the physician or NP of R374's 4.0 INR result which likely would have resulted in R374's Coumadin being held. R374 was administered Coumadin on 7/2/15 despite an abnormally high INR.  Findings were confirmed with E2 (DON) and E3 (Corporate Nurse) on 10/22/15 at approximately 11 AM.	F 157	The Staff Development Coordinator (SDC ) and or Designee will inservice staff that when a resident is on Coumadin and has an out of therapeutic range INR that the resident's physician or nurse practitioner is to be notified to see if they want to make any changes.  The Administrative Director of Nursing Services/designee will perform audits of residents that are on Coumadin to ensure that out of therapeutic range INR's are evaluated and that the resident's physician or nurse practitioner have been notified. The audits will occur daily times two weeks; then weekly for two weeks, then monthly for two months.  Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on lunch observations in the 2nd floor dining room and halls, it was determined that the facility failed to promote an environment that	F 241	It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances	12/31/15

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F 241	<p>Continued From page 8</p> <p>maintained or enhanced dignity and respect in full recognition of 11 (R6, R34, R90, R101,R107, R167, R176, R200, R296, R366 and R455) residents' individuality. Findings include:</p> <p>1. Lunch trays were observed being passed in the 200's hall on 10/8/15 with the following findings:</p> <p>a. E28 (CNA) knocked and entered R107's room with a lunch tray at 11:47 AM without asking/ waiting for permission to enter.</p> <p>b. E28 (CNA) knocked and entered R90's room with a lunch tray at 11:48 AM without asking/ waiting for permission to enter.</p> <p>c. E27 (RNAC) walked into room 222 (R90 and R107 reside there) with an oxygen tank at 11:48 AM stating "knock, knock" as he entered the room. E27 did not knock or ask/wait for permission to enter the room.</p> <p>d. E28 (CNA) knocked and entered R296's room with a lunch tray at 11:50 AM without asking/ waiting for permission to enter.</p> <p>e. E28 (CNA) knocked and entered R101's room with a lunch tray at 11:51 AM without asking/ waiting for permission to enter.</p> <p>f. E28 (CNA) knocked and entered R34's room with a lunch tray at 11:55 AM without asking/ waiting for permission to enter.</p> <p>2. During the lunch observation of the 2nd floor DR on 10/8/15 from 11:57 AM - 12:30 PM a few residents were observed with milk cartons and no cups. R176 was heard asking for "salad dressing and a glass" at approximately 12:10 PM. At 12:15</p>	F 241	<p>each resident's dignity and respect in full recognition of his or her individuality.</p> <p>1. Resident R101 and R202 no longer reside in the facility.</p> <p>Resident R34, R6, R90, R107, R167, R176, R296, R366 did not display negative outcomes from employees not knocking or asking permission to enter their rooms.</p> <p>Employees will be re-inserviced on the need to knock and ask for permission prior to entering a resident's room.</p> <p>The Staff Developer Coordinator and or designee will do daily observational audits to evaluate whether staff are in compliance with stopping , knocking and asking permission to come in.</p> <p>The Staff Development Coordinator and or designee will re-inservice employees on the proper way to enter a resident's room stopping , knocking and asking to come in.</p> <p>The Staff Developer Coordinator and or designee will do daily observational audits to evaluate whether staff are in compliance with stopping, knocking and asking permission to enter the room.</p> <p>The observational audits will take place daily for two weeks then, weekly x 2 weeks then if appropriate monthly for two months. This matter will also be reviewed at the Resident Council meeting to ensure that staff are knocking and asking for permission to enter their rooms.</p>		

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F 241	Continued From page 9 PM, a staff member brought a stack of approximately 12 ounce disposable plastic cups. Six (6) residents had cold beverages (milk or iced tea) in plastic cups: R6 and R455 had 2 plastic cups each and R167, R176, R200, and R366 each had 1 plastic cup.  Findings were reviewed with E1 (NHA) and E28 (DON) during the exit conference on 10/22/15 at approximately 4:30 PM.	F 241	<p>This will also be reviewed at our Resident Council meeting to ask if the employees are stopping, knockig and asking to enter,</p> <p>Results of these audits will be forwarded to the Quality Assurance Performance Improvement Committee for review and action as appropriate. The committee will determine the need for further audits and/ or performance improvement plans.</p> <p>2. Resident R200 no longer resides in the facility.</p> <p>Resident R6, R455, RR167, R176, R366 did not display negative outcomes from receiving plastic cups. The Adminstrative Director of Nuring Services or designee will conduct daily audits of meals in the dining room to assure that residents are not receiving plastic cups.</p> <p>The Staff Development Coordinator or designee will inservice staff to not use plastic cups in the dining room.</p> <p>The Adminstrative Director of Nursing Services or designee will conduct daily audits of meals in the dining room to assure that residents are not receiving plastic cups. The audits will be daily for two weeks then weekly for two weeks and then if appropriate monthly for two months</p>		

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F 241	Continued From page 10	F 241		
F 242 SS=D	<p><b>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</b></p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that one (R444) out of 47 Stage 2 sampled residents' right to choose and make choices while in the facility was honored. The facility failed to honor and accommodate R444's request to have a shower on the day she was admitted to the facility . Findings include:</p> <p>During an interview on 10/9/15 at 12:01 PM, R 444 stated that her scheduled shower days were on Mondays and Thursdays on the 7 AM to 3 PM shift. R444 stated she'd been admitted to the facility on a Monday, in the early evening, and had not had a shower for 5 days while in the hospital. She stated she did not receive a shower until Thursday, so a total of nine (9) days had</p>	F 242	<p>Audit results will be forwarded to the Quality Assurance Performance Improvement Committee for review and action as appropriate. The Committee will determine the need for additional audits, education or performance improvement plan.</p> <p>It is the practice of the facility that residents have the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Resident R444 no longer resides in the facility.</p> <p>The Administrative Director of Nursing Services/designee will conduct an audit of new admissions to ensure that the residents know they have the right to</p>	12/31/15

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F 242	Continued From page 11 gone by before she could get a shower.  During a second interview with R444 on 10/13/15 at 2:53 PM, she stated that on the evening of her admission to the facility, she asked E8 (RN) about getting a shower, and told E8 that it was important to her because she felt dirty and needed to wash her hair. R444 stated E8 told her she'd put her down for a shower for the next day, "but that never happened." R444 stated she did not ask again and subsequently did not receive a shower until Thursday.  On 10/14/15 at approximately 4:20 PM, E8 was interviewed. E8 confirmed that R444 told her that she'd like a shower on the evening she was admitted to the facility. E8 stated she told a CNA to try to get R444 into the shower that evening, or if not, to pass it on to the day shift, "I guess it never happened?"  The facility failed to honor and accommodate R 444's request to get a shower on the evening of her admission to the facility.  On 10/15/15 at 2:02 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 242	choose when to take a shower.  The Staff Development Coordinator/ designee will re-inservice staff on the resident right to choose when to take a shower and make choices while in our facility.  The Administrative Director of Nursing Services/designee will conduct an audit of new admissions to ensure that the residents know they have the right to choose when to take a shower. The audit will be daily for one week and then weekly for three weeks and then monthly for two months.  Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).  riate.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		12/31/15	

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F 246	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observations, it was determined that the facility failed to have call lights within reach in a public restroom and in three resident rooms ( 102, 152 and 177) out of 39 rooms. Findings include:</p> <ol style="list-style-type: none"> <li>1. On 10/8/15 at 9:00 AM, the call light pull cord in the unisex bathroom next to the Social Services Office was observed wrapped around the grab bar. The pull cord was unwrapped by the surveyor on 10/8/15 at 9:30 AM. Then on 10/9/15 at 9:00 AM, the call light pull cord was again observed wrapped around the grab bar. The call light pull cord was not within reach if someone was on the floor and needed to call for help. Finding was reviewed with E17 (FMD) on 10/09/15 at 9:30 AM.</li> <li>2. During the environmental tour on 10/14/15 between 1:00 PM and 2:30 PM with E1 (NHA) and E17 observations revealed the following:</li> <li>2. The call light pull cord in the bathroom of room 102 was observed wrapped around the grab bar. This made the call light not accessible to a resident if they fell and were on the floor.</li> <li>3. The call light pull cord in the bathroom of room 152 was observed wrapped around the grab bar. This made the call light not accessible to a resident if they fell and were on the floor.</li> <li>4. The call light pull cord in the bathroom of room 177 was observed to be missing. Therefore a resident in this room had no means to call for assistance when using the bathroom.</li> </ol>	F 246	<p>It is the practice of the facility to provide reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>The call bells in rooms 102, 152, 177 were placed within reach and not wrapped around the grab bar.</p> <p>The Administrative Director of Nursing Services/designee will audit resident bathrooms and public bathrooms to make sure the call bell is within reach and not wrapped around the grab bar.</p> <p>The Staff Development Director/designee will re-inservice staff of the need to ensure that call bells in public bathrooms and patient bathrooms are within reach and not wrapped around the grab bar.</p> <p>The Administrative Director of Nursing Services/designee audit resident bathrooms and public bathrooms to make sure the call bell is within reach and not wrapped around the grab bar. This audit will be daily for two weeks, then weekly for two weeks and then monthly for two months.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/</p>	

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F 246	Continued From page 13  Findings were confirmed with E1 and E17 on 10/14/15 during the environmental tour.  Findings were reviewed with E1 and E2 (DON) on 10/22/15 at approximately 3:30 PM.	F 246	or a performance improvement plan (PIP).		
F 253 SS=E	<b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b>  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on observations and interviews during the environmental tour with E1 (NHA) and E17 (FMD) on 10/14/15 between 1:00 PM and 2:30 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 21 out of 39 rooms reviewed. Findings include:  The following observations were made during the environmental tour:  1. Room 121 - Left window curtain had stains; - Air conditioning (A/C) unit vent was being held up by tape; - Wall near the foot of bed had scuff marks; - Wallpaper peeling near the foot of bed; - Floor corner molding at foot of bed in disrepair; - Nail on wall next to bathroom door protruding; - Bathroom entrance doors had chips; - Peeling wallpaper above front door.	F 253	It is the practice of the facility to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior.  Resident room number 121, 122, 128, 178, 130, 131, 143, 144, 146, 148, 152, 155, 161, 206, 207, 210, 213, 214, 217, 219, 220 will be repaired.  The Administrator and Maintenance Director or designee will complete weekly environmental rounds to evaluate if the facility is maintaining a sanitary, orderly and comfortable interior. Any findings will be addressed. During these rounds the environmental checklist form will be used to note any findings. Wallpaper issues, scrapes or rough door surfaces, ceiling tiles will be included in these rounds.  The Staff Development Coordinator will	12/31/15	

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F 253	Continued From page 14  2. Room 122 - Wall scuff mark at head of bed; - Wall scuff mark near foot of bed; - Water damage on bathroom ceiling.  3. Room 128 - Peeling wallpaper by window; - Ceiling in the bathroom above toilet has water damage.  4. Room 178 - Chipped paint by window.  5. Room 130 - Bathroom wall behind the toilet to its right has peeled paint.  6. Room 131 - Lower bathroom wall next to the toilet bowl was cracked with hole that affected the molding.  7. Room 143 - Wall in front of A bed had a dark scrape along it.  8. Room 144 - Rip in the wall under sink.  9. Room 146 - Walls in bathroom spackled and unpainted; - Long black streaks on wall in front of the beds; - Behind the headboard in A bed there are scrapes in the wallpaper.  10. Room 148 - Bathroom walls were spackled and unpainted.  11. Room 152 - Peeled wall paint behind head of the bed.	F 253	inservice staff on identifying and communicating environmental issues using the electronic TELS system or the 24 hour report.  The Administrator and Maintenance Director or designee will complete environmental rounds to evaluate if the facility is maintaining a sanitary, orderly and comfortable interior. Any findings will be addressed. During these rounds the environmental checklist form will be used to note any findings. Wallpaper issues, scrapes or rough door surfaces, ceiling tiles will be included in these rounds. These rounds will occur daily for one week, then weekly for three weeks, then if appropriate monthly for two months.  Results of the enviromental rounds conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).		

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F 253	Continued From page 15 - Scrapes and peeling paint observed on the bathroom wall.  12. Room 155 - Scrapes at base of bathroom door frame.  13. Room 161 - Toilet in disrepair with no cover on the bowl. Toilet cover was found behind the toilet bowl; - Door scrapes on inside of the bathroom door; - Bathroom door frame was scraped and black in color.  14. Room 206 - A/C unit was dirty; - Front of bathroom door wood gouged; - Inside of bathroom left of door heating unit had debris inside; - Wallpaper above bathroom heating unit discolored and torn off; - Bathroom wall lacked wallpaper and had two holes in one wall.  15. Room 207 - Wallpaper peeling above head of bed; - Bathroom door was scraped; - Entry door chipped at edge near handle with splinters; - Wall behind entry door had indent from door handle; - Bathroom inside door scraped along bottom.  16. Room 210 - Bathroom door scraped across bottom; - Bathroom wall was scraped in corner left side; - Three holes in wall next to the left of mirror; - Wallpaper along wall on right side of bed room dirty.	F 253			

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F 253	Continued From page 16 17. Room 213 - Bathroom sink right at front corner chipped.  18. Room 214 - Scrapes on bathroom door.  19. Room 217 - Bathroom ceiling tiles stained above toilet area; - Bathroom heater unit dusty and dirty with wallpaper peeling above it.  20. Room 219 - A/C unit dirty; - Bathroom sink near overflow drain rusting; - Bathroom by light fixture had hole on right side wall.  21. Room 220 - Entire lower wall on left side of room was dirty.  Findings were confirmed with E1 and E17 during the environmental tour.  Findings were reviewed with E1 and E2 (DON) on 10/22/15 at 3:30 PM.	F 253			
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS  The facility must provide adequate and comfortable lighting levels in all areas.  This REQUIREMENT is not met as evidenced by:  Based on observations and interview, it was determined that the facility failed to provide adequate and comfortable lighting levels in two rooms (102b and 206b) out of 39 rooms reviewed	F 256	It is the practice of the facility to provide adequate and comfortable lighting levels in all areas.	12/31/15	

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F 256	Continued From page 17 Findings include:  During the environmental tour on 10/14/15 between 1:00 PM and 2:30 PM with E1 (NHA) and E17 (FMD) observations revealed the following:  1. The overbed light for room 102B was observed with the pull cord missing, preventing it from turning on.  2. The overbed light for room 206B was observed with the pull cord missing, preventing it from turning on.  Findings were confirmed by E1 and E17 on 10/14 /15 during the environmental tour.  Findings were reviewed with E1 and E2 (DON) on 10/22/15 at approximately 3:30 PM.	F 256	The overbed light in room 102B and 206B both have pull cords.  The Maintenance Director and or designee will audit rooms to ensure pull cords are present.  The Staff Development Corrdiantor/ designee will inservice staff to report any missing pull cords and to note missing pull cords in the electronic TELS system or the 24 hour report.  The Maintenance Director and or designee will audit rooms to ensure pull cords are present. The audits will be conducted daily for one week, then weekly for 3 weeks three weeks, then if appropriate monthly times two months.  Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		12/31/15	

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F 272	<p>Continued From page 18</p> <p>least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on clinical record reviews and interviews, it was determined that the facility failed to comprehensively and/or accurately assess seven (R214, R324, R355, R359, R374, R396, and R 453) out of 47 Stage 2 sampled residents. The facility failed to comprehensively assess R214's, R355's, R359's and R396's urinary incontinence upon admission and/or readmission to the facility.</p>	F 272	<p>It is the facility practice conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Resident #214, #355, #374, #453 and # 396 no longer reside in the facility.</p>		

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F 272	<p>Continued From page 19</p> <p>For R374, the facility failed to accurately code the MDS in the area of behaviors. For R324, the facility failed to accurately reflect the resident's terminal prognosis. For R453, the facility failed to accurately code active diagnoses for which the resident was receiving treatment. Findings include:</p> <p>1. The eMAR from 9/29/15 through 10/5/15 revealed R453 was receiving medication for management of symptoms of Parkinson's Disease and anticoagulant medication for a DVT.</p> <p>Review of the admission MDS assessment, dated 10/5/15, failed to code under "Active Diagnosis" that R453 had Parkinson's Disease and a DVT. The facility failed to ensure a comprehensive, accurate assessment was completed.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during an interview on 10/20/15 at 12:19 PM.</p> <p>2. Cross refer F315, example #2 R355 was admitted to the facility on 5/16/15.</p> <p>The nursing "Patient Admission/Readmission Screen," and "Nursing Admission Evaluation," both dated 5/16/15, stated R355 was continent of bladder.</p> <p>The 5/18/15 physician's H&amp;P stated R355 was occasionally incontinent of bladder.</p> <p>The 5/23/15 admission MDS assessment stated R355 was independent for daily decision making skills, required extensive assist of one (1) staff for bed mobility, transfer and toilet use. This MDS assessment also stated R355 was occasionally</p>	F 272	<p>1. R#453 no longer resides in the facility</p> <p>2. Cross refer to F315 example 2, R3 355 no loner resides in the facility.</p> <p>3. Cross refer to F315 example 1 R#359 has had her toileting needs evaluated via a 3 day voiding diary and her urinary status comprehensively assessed to the extend possible identified risks/underlying causes of residents incontinence and its impact upon residents bladder function, mood and cognition.</p> <p>4a. Cross refer to F315 example 4 Resident #396 no longer resides in the facility</p> <p>4b. - resident #396 no longer resides in facility.</p> <p>5. Cross refer to F315 example #3. Resident #214 no longer resides in facility.</p> <p>6. R#324 continues to receive hospice services and has had MDS modified to accurately code terminal progrognosis and hospice.</p> <p>7. R#374 no longer resides at the facility.</p> <p>The MDS Coordinator/designee will conduct an audit to identify residents currently residing in the facility going back 30 days that have a diagnosis of Parkinsons and Deep Vein Thrombosis, have a termianl prognosis and are receiving Hospice services and residents</p>		

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F 272	<p>Continued From page 20</p> <p>incontinent of bladder during the assessment period (5/17/15 through 5/23/15) and there was no trial of a toileting program.</p> <p>R355's clinical record lacked evidence of a 3 day voiding diary having been completed to determine patterns of incontinence. The facility failed to comprehensively assess R355's urinary status.</p> <p>Findings were reviewed on 10/21/15 at 4:30 with E3 (Corporate Nurse) and on 10/22/15 at approximately 4:00 PM during the exit conference with E1 and E2.</p> <p>3. Cross refer to F315, example #1 On 5/21/15 at 10:02 PM, "Patient Admission/ Readmission Screen" stated that R359's " Cognitive Skills for Daily Decision Making were moderately impaired: decisions poor; cues/ supervision required". This admission screening indicated that R359 was continent of bladder.</p> <p>The 5/28/15 -Admission MDS assessment identified that R359 was occasionally incontinent of bladder, and there was no trial of a toileting program. R359's diagnoses included Dementia and impaired vision. R359's cognition was severely impaired and needed extensive assist of one staff with her ADLs which included transferring and toilet use. R359's clinical record lacked documentation that the facility implemented/completed a 3-day Voiding Diary to assess this resident's voiding patterns and facilitate providing care to avoid or reduce the frequency of her incontinence episodes.</p> <p>The facility failed to comprehensively assess R 359's toileting needs by completing a voiding</p>	F 272	<p>that trigger for documented behaviors.</p> <p>Identified Residents will have their last completed MDS reviewed to validate that sections E, I, J is accurately captured in the comprehensive assessment.</p> <p>An initial audit will be conducted by the Administrative Director of Nursing Services/designee to identify residents that currently reside in the facility and are identified as frequently incontinent and those identified as having a decline in urinary continence based upon their most recent MDS.</p> <p>Identified residents will have a Bladder Diary initiated and completed, their urinary incontinence assessed and care plans developed/updated to reflect individualized toileting plan/approaches where voiding patterns are identified.</p> <p>Newly admitted/readmitted residents will have a bladder diary completed upon admission and if identified as incontinent, type of incontinence will be assessed and incontinence care plan developed to include individualized approaches/ interventions and revised as needed.</p> <p>Residents that are not identified as frequently incontinent, having a decline in continence or newly admitted/readmitted will have a bladder diary completed with their next scheduled MDS. MDS will provide the Administrative Director of Nursing Service with a weekly schedule.</p>		

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F 272	<p>Continued From page 21</p> <p>diary, and failed to identify the risks and/or determine underlying causes to the extent possible of the resident's incontinence and the impact upon the resident's bladder function, mood and cognition.</p> <p>This finding was discussed with E1, E2, and E3 on 10/20/15 at approximately 4:00 PM.</p> <p>4A. Cross refer F315, example #4 R396 was admitted to the facility on 7/15/15.</p> <p>Review of the Patient Admission/Readmission Screen, dated 7/15/15 and timed 6:43 PM, stated that R396 was "independent: decisions consistent /reasonable" for daily decision making. R396 was continent of bladder and needed assistance with toileting.</p> <p>R396's admission MDS assessment, dated 7/22/15, indicated the resident was cognitively intact, required extensive assistance with toileting with two person physical assist, was occasionally incontinent of urine, and was not on a trial or toileting plan.</p> <p>There was lack of evidence in R396's clinical record that upon admission a bladder assessment or a 3-Day Voiding Diary was done. The facility failed to ensure a voiding diary was completed and analyzed in order to develop an individualized toileting plan.</p> <p>4B. R396 was readmitted to the facility on 9/22/15</p> <p>Review of the Patient Admission/Readmission Screen, dated 9/22/15 and timed 9:38 PM, stated that R396 was "independent: decisions consistent</p>	F 272	<p>Regional Minimum Data Sets(MDS) coordinator/designee will in-service MDS staff on requirements of completing an accurate comprehensive assessment to include validating information obtained during look back period is correct, capturing of the resident's active diagnosis' and completing section J as iot relates to Hospice and termial prognosis.</p> <p>Regional Minimum Data Sets Coordinator ( MDS)/designee will in-service Social Services on accurately coding/capturing information during look back period relative to section E behaviors.</p> <p>Licensed nursing staff will be re-educated by Administrative Director of Nursing Services/designee on use of bladder diary, assessing incontinence, developing/ assessing/revising care plans to include individualized approaches/interventions for urinary incontinence as indicated.</p> <p>Administrative Director of Nursing Services and/or Assisstant Director of Nursing/Staff Development Coordinator/ Director of Care Delivery Services will review residents bladder diary findings in Eagle Room and ensure those residents identified as incontinent have had their incontinence assessed and care plan developed to include individualized approaches/interventions where voding patterns are identifiable.</p> <p>Administrative Director of Nursing Services/designee/Interdisciplinary Team</p>		

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F 272	<p>Continued From page 22</p> <p>/reasonable" for daily decision making. R396 was continent of bladder and needed assistance with toileting.</p> <p>R396's readmission MDS assessment, dated 9/29/15, indicated the resident was cognitively intact, required extensive assistance with toileting with two person physical assist, was frequently incontinent of urine and was not on a trial or toileting plan.</p> <p>Again, there was a lack of evidence in the clinical record that upon readmission a bladder assessment or a 3-Day Voiding Diary was done. The facility failed to ensure a voiding diary was completed and analyzed in order to develop an individualized toileting plan.</p> <p>Findings were reviewed with E4 (DCD) on 10/14/15 at 2:45 PM.</p> <p>The facility failed to comprehensively assess R 396's urinary incontinence status upon her 7/15/15 admission and her 9/22/15 readmission, failed to complete a voiding diary, failed to complete a thorough bladder assessment and develop an individualized toileting plan.</p> <p>5. Cross refer F315, example #3 R214 was admitted to the facility on 4/8/15.</p> <p>The nursing admission screen, dated 4/8/15 and timed 9:15 PM, stated that R214 was independent with daily decision making, continent of bladder, required assistance for toileting and was ordered diuretic medication.</p> <p>The admission MDS assessment, dated 4/15/15, stated R214 was cognitively intact and</p>	F 272	<p>will review MDS triggered incontinence Care Area Assessments in Eagle Room to ensure that a care plan is developed/ updated/and/or revised to include individualized approaches/interventions.</p> <p>The Administrative Director of Nursing Services/designee will in-service licensed nursing staff on accurately completing the urinary continence portion of the admission/re-admission screen.</p> <p>Minimum Data Sets(MDS) Coordinator/designee will complete audits of MDS coding focusing on sections E, I, J to evaluate that the MDS comprehensive assessment is accurate.</p> <p>Audits will be performed weekly times weeks 4, then if appropriate monthly times 2 months.</p> <p>Administrative Director of Nursing Services/designee will conduct audits to ensure that residents identified as frequently incontinent, identified as having a decline in incontinence per Minimum Data Sets( MDS) and newly admitted/re-admitted patients will be reviewed to ensure that a bladder diary was completed, urinary incontinence assessed and care plane developed to reflect individualized toileting plan/approaches as indicated.</p> <p>Audits will be performed daily times 2 weeks, then weekly times 2 weeks then if appropriate monthly times2 months.</p>		

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F 272	<p>Continued From page 23</p> <p>occasionally incontinent of bladder.</p> <p>R214's clinical record lacked evidence of a comprehensive assessment of her urinary incontinence, including a bladder diary to determine her voiding pattern, when the 4/15/15 MDS assessment identified her as being occasionally incontinent.</p> <p>From 4/8/15 to 8/26/15, R214 was hospitalized several times and readmitted to the facility on 5/13/15, 6/17/15 and 8/7/15. The clinical record lacked evidence that R214 was comprehensively assessed for urinary incontinence upon each readmission to the facility, particularly when MDS assessments identified her as being either occasionally or frequently incontinent.</p> <p>In an interview on 10/19/15 at 3:21 PM, E4 stated that bladder diaries were not completed for R214 upon admission and three (3) subsequent readmissions to the facility.</p> <p>Findings were reviewed on 10/20/15 at 3:21 PM with E1, E2 and E3. The facility failed to comprehensively assess R214 for urinary incontinence upon admission to the facility on 4/8/15 and three (3) subsequent readmissions.</p> <p>6. The facility provided, "CMS's RAI Version 3.0 Manual", dated May 2010, which stated "J1400 Prognosis Coding Instructions - Code 1, yes: if the medical record includes physician documentation that the resident has a terminal disease or that the resident's condition or chronic disease may result in a life expectancy of less than 6 months or whether the resident is receiving hospice services."</p>	F 272	<p>Administrative Director of Nursing Services/designee will audit patient admission/re-admission screen to validate that the urinary incontinence portion has been accurately completed.</p> <p>Audits will be performed daily time 2 weeks, then weekly times 2 weeks then if appropriate monthly times 2 months.</p> <p>Administrative Director of Nursing Services/designee will evaluate the weekly Minimum Data Sets schedule and identify patients that have not had their urinary continence assessed and will have a bladder diary completed.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p>		

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F 272	<p>Continued From page 24</p> <p>Additionally, the same Manual defined Hospice Services as "a program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions."</p> <p>Review of R324's physician progress notes revealed the following:</p> <ul style="list-style-type: none"> <li>- 7/15/15, "...Confused and not able to engage in meaningful conversation...Dementia - progressive &amp; rapid decline";</li> <li>- 7/23/15, stated that R324 continues to do poorly and "He is appropriate for hospice care";</li> <li>- 7/28/15, "Steady decline continues...Progressive Dementia...poor prognosis...on skilled nursing for now eventual transition to hospice discussed with nursing";</li> <li>- Patient History and Physical dated 8/13/15, stated that R324 was starting Hospice services on 8/16/15, he had advanced dementia and was on comfort care;</li> <li>- 8/14/15, "...transferring to hospice 8/16/15... Prog (Progressive) Dementia...comfort care/ hospice...".</li> </ul> <p>According to R324's Significant Change MDS assessment, dated 8/19/15, R324 was on Hospice care. However, the MDS assessment section J1400 entitled "Prognosis" was not checked and/or identified to indicate that R324 had "a condition or chronic disease that may result in a life expectancy of less than 6 months."</p> <p>In a interview, on 10/20/15 at 8:35 AM, E23 (RN, MDS Coordinator) stated R324's Section J1400 was coded as "No" because there was no physician documentation that specifically stated that the resident had a life expectancy of 6 months.</p>	F 272			

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F 272	Continued From page 25  In a interview, on 10/20/15 at 11:46 AM, E24 (RN, MDS Coordinator) stated she only codes the area of life expectancy of less than six months if a physician has specifically documented that in the resident's clinical record. E24 stated that she would not code Section J1400 as "Yes" just because the resident was receiving Hospice Services, despite the instructions on the Manual.  The facility failed to accurately reflect R324's prognosis on his 8/19/15 Significant Change MDS  At approximately 11:55 AM on 10/20/15, findings were discussed with E1, E2 and E3.  7. The facility failed to have an accurate admission/5 day MDS dated 6/19/15, R374 was coded as having no rejection of care, however, there were documented rejections of care in the progress notes during the 7 day look back period. On 6/16/15, R374 had no bowel movements for 3 days and he refused Milk of Magnesia and on 6/18/15, R374 refused lunch, so his Insulin had to be held. R374 was incorrectly coded a "0" for behaviors on the 6/19/15 MDS when he should have been coded a "1".  Findings were confirmed with E27 (RNAC) during an interview on 10/22/15 at 10:20 AM.	F 272			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate	F 278		12/31/15	

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F 278	<p>Continued From page 26</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview it was determined that the facility failed to have an accurate 14 day MDS assessment to reflect the resident's current status for 1 (R163) out of 47 Stage 2 sampled residents. Findings include:</p> <p>R163's 6/24/15 admission/5 day MDS assessment listed an admission weight of 141 lbs . R163's 7/22/15 14 day MDS listed a weight of 124 lbs., a 17 lb. or a 12% weight loss in one month.</p>	F 278	<p>It is the practice of the facility that the assessment accurately reflect the resident's status.</p> <p>Resident R163 no longer resides in the facility.</p> <p>The Dietician/Designee will conduct an audit on residents that currently reside in the facility over the last 30 days to identify those with weight loss of 5% or more in 30 days and/or 10% or more in 180 days.</p>		

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F 278	Continued From page 27 The facility failed to code R163's 7/22/15 MDS assessment for a significant weight loss (the MDS does not have the capacity to code for a severe weight loss).  Findings were confirmed with E27 (RNAC) during an interview on 10/19/15 at 2:40 PM.	F 278	Registered dietician will review residents identified with a significant weight loss that had an MDS completed in the last 30 days to evaluate the MDS assessment and coding of section K is accurate.  The Regional Case Mix Specialist or designee will inservice the Dietician on accurate assessment when coding the section K during the MDS look back period when a significant weight loss of 5 % or in 30 days and /or 10% or more in 180 dyas identified.  Minimun Data Sets(MDS) Coordinator/ Designee will audit dietician notes durng the MDS look back period to see if the residnet triggered for a weight loss and will then in comparison the data contained within the note to MDS section K daily for 4 weeks then weekly times 4, then if appropriate monthly times one.  The audit results will be forwarded to the Quality Assurance Performance Improvement Committee for review and appropriate action.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care	F 279		12/31/15	

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F 279	<p>Continued From page 28</p> <p>plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview, it was determined that for one (R396) out of 47 Stage 2 sampled residents, the facility failed to develop an individualized care plan based on an identified need. Findings include: Cross refer F315, example #4. 1A. R396's admission MDS assessment, dated 7/22/15, stated the resident was cognitively intact, required extensive assist of two (2) staff with toileting, was occasionally incontinent of urine and was not on a trial or toileting plan. The CAAs triggered and was checked for care planning decision in the area of urinary incontinence.</p> <p>Review of R396's care plans lacked evidence of a care plan for urinary incontinence.</p> <p>1B. R396's significant change MDS assessment, dated 9/29/15, indicated the resident was cognitively intact, required extensive assistance</p>	F 279	<p>It is the facilities practice to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>1. A/B # 396 no longer resides in the facility.</p> <p>An audit will be conducted by the Adminstrative Director of Nursing/ Designee of the MDS 3.0 triggered Incontinence CAA report to identify residents currently residing in the facility that trigger for urinary incontinence over the last 30 days.</p> <p>Residents identified that triggered for</p>		

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F 279	Continued From page 29 with toileting with two person physical assist, was frequently incontinent of urine and was not on a trial or toileting plan. The CAAs triggered and was checked for care planning decision in the area of urinary incontinence.  Review of R396's care plans lacked evidence of a care plan for urinary incontinence.  During an interview on 10/13/2015 at 2:50 PM, E4 (DCD) confirmed that a care plan for incontinence was never initiated although urinary incontinence had triggered in the CAAs.  The facility failed to care plan on two occasions for R396's urinary incontinence when CAAs triggered for urinary incontinence on the Admission MDS, dated 7/22/15, and upon readmission for a Significant Change MDS, dated 9/29/15. An incontinence care plan was only initiated after it was brought to the facility's attention by the surveyor on 10/13/15.	F 279	urinary incontinence CAAs will have their care plans reviewed /revised to ensure that Incontinence CAA has had a corresponding Incontinence care plan developed/ reviewed/revised to meet the residents needs and accurately reflect the residents cuurent urinary status.  Adminstrative Director of Nursing/ Designee will re-inservice the Licensed nursing staff and the Director Care of Care Delivery staff that are responsible for following up care planning to ensure that the MDS triggerd Incontinence CAAs are addressed in the residents care plan.  MDs/Designee will ensure that the MDS Incontinence CAAs are attached to the 24 hour report and brought through EAGLE Room for the Administrative Director of Nursing/designee to audit that the MDS triggered Incontinence CAAS have a corresponding Incontinence care plan developed/reviewed/revised to meet the residents needs and accurately reflect the current urinary status daily times 4 weeks, then weekly times 4 weeks then if appropriate monthly times one.  The results of these audits will be brought throught the Quality Assurance Performance Improvement Committee for review.They determine the need for futher audits and or action plans.		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged	F 280		12/31/15	

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F 280	<p>Continued From page 30</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview, it was determined that the facility failed to revise the care plans to reflect actual care needs for four (R 171, R214, R355 and R359) out of 47 Stage 2 sampled residents. Findings include:</p> <p>Cross refer F312</p> <p>1. R171's care plan entitled, "ADL self care deficit related to physical limitation, parkinsons", created on 7/26/10 and last reviewed on 9/21/15, had the goal to participate in self care tasks at the highest practicable level of functioning. Interventions included: "...Assist with daily hygiene, grooming, dressing, oral care and eating as needed...".</p> <p>R171's dental hygienist consult, dated 2/12/15,</p>	F 280	<p>It is the practice of the facility to have a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>		

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F 280	<p>Continued From page 31</p> <p>stated "Comments: Showed (Name of E9/LPN), mod, heavy bleeding gen; will have CNA follow recommendations below. Need to minimize bacteria in mouth...Recommendations: Please brush gums/teeth/tongue at least once daily for patient. Wipe all gums with large 4 x 4 gauze and antimicrobial rinse".</p> <p>The ADL care plan failed to be revised to include dental services as needed and the 2/12/15 dental services' recommendations.</p> <p>On 10/20/15 at 12:45 PM, E9 (LPN) confirmed the findings.</p> <p>2. Cross refer F315, example #2 R355 was admitted to the facility on 5/16/15 with diagnoses that included diabetes, depression, chronic pain and idiopathic peripheral autonomic neuropathy.</p> <p>The nursing "Patient Admission/Readmission Screen," and "Nursing Admission Evaluation," both dated 5/16/15, stated R355 was continent of bladder.</p> <p>The 5/18/15 physician's H&amp;P stated R355 was occasionally incontinent of bladder.</p> <p>The 5/23/15 admission MDS assessment stated R355 required extensive assist of one (1) staff for bed mobility, transfer and toilet use, and that he was occasionally incontinent of bladder.</p> <p>On 5/29/15 a urinary incontinence care plan was developed.</p> <p>A 60 Day Medicare assessment, dated 7/16/15, stated R355's daily decision making skills were</p>	F 280	<p>1. Resident R171 has had her ADL care plan revised to reflect actual care needed related to dental services and recommendations.</p> <p>The Adminstrative Director Nursing Services or designee will conduct an audit to identify residents that have dental consults and recommendations to ensure that the care plan has been updated.</p> <p>The Staff Development Coordinator or designee will re-inservice nursing staff on updating the care planning process to include review /revision relating to capturing urinary tract infections, incontinence and dental consults and recommendations.</p> <p>The Adminstrative Director Nursing Services or designee will conduct an audit of residents with dental service consults and or recommendations to ensure the care plan has been updated. A Audit will be conducted weekly times 4 weeks then if appropriate, monthly times 2 months.</p> <p>The results will be forwarded to the Quality Assurance Performance Improvement Committee for review and appropriate follow up.</p> <p>R355 cross reference F315</p> <p>2. Resident R315 no longer resides in the facility.</p> <p>The Adminstrative Dircetor Nursing</p>		

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F 280	<p>Continued From page 32</p> <p>moderately impaired and he required extensive assist of two (2) staff for toilet use. The 7/16/15 assessment also stated R355 was now frequently incontinent during the assessment period (7/10/15 through 7/16/15) and there was no trial of a toileting program. This was a decline from the 5/23/15 MDS assessment, when R355 was occasionally incontinent.</p> <p>The facility failed to re-evaluate R355 and failed to review and revise the incontinence care plan after R355 experienced a decline in continence.</p> <p>Findings were reviewed on 10/21/15 at 4:30 with E3 (Corporate Nurse) and on 10/22/15 at approximately 4:00 PM during the exit conference with E1 (NHA) and E2 (DON).</p> <p>3. Cross refer F315, example #1 On 5/21/15 at 10:02 PM the admission screening entitled "Patient Admission/Readmission Screen" record indicated that R359 was continent of bladder. R359's cognitive skills for daily decision-making were moderately impaired: decisions poor; cues/supervision required.</p> <p>According to the clinical record, R359 was found incontinent of urine on 5/23/15 at 2:42 PM, 5/24/15 at 8:34 AM, 5/24/15 at 2:43 PM, 5/25/15 at 3:45 PM, and 5/27/15 at 7:05 AM.</p> <p>On 5/27/15, the facility initiated a care plan entitled, "Urinary incontinence related to dementia, impaired mobility. The care plan goals were: "Will have no complications due to incontinence and Will be maintained in as clean and dry dignified state as possible". Interventions included: "Provide assistance with toileting, Provide incontinent care as needed,</p>	F 280	<p>Services or designee will conduct an audit on resident identified as incontinent post completion of Bladder diary and analysis to ensure that the care plan has been updated to reflect current voiding schedule and approaches used.</p> <p>The Staff Development Coordinator or designee will re-inservice nursing staff on updating the care planning process to include review /revision relating to capturing urinary tract infections, incontinence and dental consults and recommendations.</p> <p>The Administrative Director Nursing Services or designee will conduct a audits on resident identified as incontinent to ensure care plans are updated to reflect type of incontinence if identifiable and voiding schedule post review of bladder diary. A Audit will be conducted weekly times 4 weeks, then if appropriate, monthly times 2 months.</p> <p>The results will be forwarded to the Quality Assurance Performance Improvement Committee for review and appropriate follow up.</p> <p>3.R359 cross reference F315, continues to reside at the facility and has had a her care plan updated to refelect current urinary incontinence and voiding schedule, Urinary tract infection resolved.</p> <p>R214 cross reference F315 Resident no longer resides in the facility.</p>		

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F 280	<p>Continued From page 33</p> <p>Report signs and symptoms of UTI...".</p> <p>The Admission MDS assessment, dated 5/28/15 identified that R359 was occasionally incontinent of bladder between 5/21/15 through 5/28/15, the seven (7) day review time period.</p> <p>On 5/30/15 and 5/31/15, R359 showed symptoms of impending UTI and on 6/1/15, a urine specimen was obtained and sent to the laboratory for testing.</p> <p>A care plan entitled, "Infection of urinary tract" was initiated on 6/1/15. The goal of this care plan was: "Resident's Infection will be resolved without complications". The interventions were: "Administer medication per physician orders; Maintain precautions as indicated; obtain labs as ordered and notify physician results; Record temperature as clinically indicated".</p> <p>On 6/2/15, R359 tested positive for a UTI.</p> <p>The facility failed to review and revise the urinary incontinence and UTI care plans, to include the following: restoration of R359's normal bladder function as much as possible; prevention of a UTI; completion of a urinary incontinence evaluation using a voiding diary; and implementation of an individualized toileting schedule based on the results of the voiding diary as per the facility's guideline.</p> <p>The facility failed to reassess the effectiveness of the interventions and revised the plan of care and implement interventions with input from the result of the voiding diary assessment to meet the needs of R359.</p>	F 280	<p>The Administrative Director Nursing Services or designee will conduct audits on residents identified as having Urinary Tract Infections to ensure that a care plan is in place.</p> <p>The Staff Development Coordinator or designee will re-inservice nursing staff on updating the care planning process to include review /revision relating to capturing urinary tract infections, incontinence and dental consults and recommendations.</p> <p>The Administrative Director Nursing Services or designee will conduct audits of residents identified as having a urinary tract infection to ensure the care plan is completed and accurately reflects measures in place to treat. The audits will be conducted weekly for 4 weeks then if appropriate monthly times 2 months.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p>		

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F 280	Continued From page 34 This finding was discussed with E1, E2 and E3 on 10/20/15 at approximately 4:00 PM.  4. Cross refer F315, example #3 R214 was admitted to the facility on 4/8/15.  The admission MDS assessment, dated 4/15/15, stated that R214 was occasionally incontinent of bladder.  On 4/20/15, R214 was care planned for urinary incontinence with approaches that included " remind and assist as needed with toileting at routine times such as upon arising in AM, with meals and at bedtime; adjust toileting times to meet patient needs; and provide incontinent care as needed".  A significant change MDS assessment, dated 6/24/15, stated that R214 was frequently incontinent of bladder, which was a decline from her previous MDS assessment, dated 5/27/15, that stated she was occasionally incontinent of bladder.  On 6/29/15, R214's urinary incontinence care plan remained the same when she was occasionally incontinent of bladder, even though the 6/24/15 MDS assessment showed a further decline of her bladder continence.  Findings were reviewed on 10/20/15 at 3:20 PM with E1, E2 and E3. The facility failed to review and revise R214's urinary incontinence care plan when she went from occasionally to frequently incontinent of bladder.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		12/31/15	

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F 309	Continued From page 35  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by : Based on observations, record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the plan of care for three (R86, R453 and R447) out of 47 Stage 2 sampled residents. The facility failed to correctly transcribe a PRN physician's order for Xanax ( medication for anxiety), and incorrectly transcribed it as a standing order, resulting in R 453 receiving it regularly instead of when needed. For R86, the facility failed to monitor fluid restriction, and for R447, the facility failed to provide sliding scale Insulin coverage before meals as ordered on 10/8/15. Findings include:  1. The facility "Fluid Restrictions" Guideline, dated January 2013, states "...The Fluid Restriction Worksheet...is used to plan the fluids to be given. This worksheet is completed by the registered dietitian or designee...The registered dietitian or designee duplicates the Fluid Restriction Worksheet and provides copy to nurse who places in MAR and to dietary to enter beverage preferences into the dietary tray ticket software program...Water at bedside, if requested, is considered when planning the beverages for a	F 309	It is the practice of this facility that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  1. Resident R447 continues with physician order for sliding scale insulin coverage before meals, which she is receiving.  2. Resident R453 no longer resides at the facility.  3. Resident R86 no longer resides at the facility.  An audit will be conducted by the Administrative Director of Nursing or designee on residents that currently reside in facility and are identified as being on a fluid restriction.  An audit will be conducted by the ADNS or		

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F 309	<p>Continued From page 36 fluid restriction..."</p> <p>R86 was admitted to the facility on 9/21/15. R86's admission orders, dated 9/21/15, included a 1200 ml fluid restriction per 24 hours.</p> <p>A care plan, dated 9/24/15, for "Nutritional status" included the intervention, "fluid restrictions as ordered."</p> <p>The Fluid Restriction Worksheet Section A, dated 9/24/15 and completed by the RD, stated R86 was on a 1200 ml fluid restriction. The following were the allotment amounts for nursing: - day shift (7 AM to 3 PM) = 150 ml; - evening shift (3 PM to 11 PM) = 150 ml; - night shift (11 PM to 7 AM) = 120 ml; Section B (Fluid Patterns for Meals and Between Meal Snacks) of the 9/24/15 Fluid Restriction Worksheet, stated R86 was to have the following per 24 hours for dietary: - 4 oz or 120 ml of apple juice for breakfast; - 6 oz or 180 ml hot tea for lunch; - 8 oz diet soda for dinner; - 8 oz diet soda for snack; Totaling 780 ml per 24 hours for the dietary allotment.</p> <p>The undated CNA Kardex stated "Maintain 1200 ml fluid restriction as ordered."</p> <p>Review of electronic CNA data from 9/24/15 through 10/15/15 under the task "Fluids offered," revealed the following: - 9/24/15 documented fluids offered and accepted three times on the 11 PM to 7 AM shift; - 9/25/15 through 10/15/15 documented fluids were offered and accepted once per shift on the 11 PM to 7 AM shift.</p>	F 309	<p>designee on residents that currently reside in the facility to identify residents receiving Xanax.</p> <p>An audit will be conducted by the ADNS or designee on residents who currently reside in the facility that have been identified as receiving sliding scale insulin coverage.</p> <p>The Staff Development Coordinator or designee will inservice licensed nursing staff on the need to adhere to residents ordered fluid restrictions, transcription of restrictions onto care plan and TASK, and to refrain from having water pitchers at bedside unless accounted for in the Dietician's fluid restriction worksheet.</p> <p>The Staff Development Coordinator or designee will inservice licensed nursing staff on the need to document acceptance of fluids offered per resident's restrictions on the Medication Administration Record and how to view the fluid restriction worksheet in the electronic medical record</p> <p>The Staff Development Coordinator or designee will inservice licensed nursing staff on timely administration of sliding scale insulin coverage per physician order</p> <p>The Staff Development Coordinator or designee will inservice licensed nursing staff on accurately transcribing physician orders for Xanax onto the Medication Administration Record.</p>		

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F 309	<p>Continued From page 37</p> <p>There was no documentation of how much fluid was offered to and consumed by R86, nor was there any evidence whether this was fluid that had not been consumed by the resident from another allotment amount.</p> <p>Review of the eMAR and eTAR from 9/22/15 through 10/14/15 lacked evidence of any monitoring of fluid amounts for R86, nor was there any mention of the resident being on fluid restriction and what the allotted amount was.</p> <p>Nurse's notes reviewed from 9/22/15 through 10/14/15 stated on multiple occasions that "fluids were offered and encouraged."</p> <p>The facility failed to have a system in place to ensure accurate monitoring of R86's fluid restriction.</p> <p>The following observations were made of R86: - 10/13/15 at 8:45 AM - seated in room finishing breakfast; had consumed a 6 oz cup of hot tea (not the 4 oz of apple juice or fluid allotted for breakfast); a 16 oz white Styrofoam cup filled with water, a 4 oz container of apple juice and three (3) 8 oz cans of soda observed on nightstand. R86 stated that the Styrofoam cup of water "was brought in last night, I told them not to bring it but they do anyway." - 10/13/15 at 12:16 PM - eating lunch in room, has 8 oz can of soda; Styrofoam cup with water and three (3) cans of 8 oz soda remain on nightstand. - 10/14/15 at 11:00 AM - 16 oz white Styrofoam cup on nightstand filled with water.</p> <p>During an interview on 10/14/15 at 2:19 PM, E19 (CNA) stated that in their electronic</p>	F 309	<p>The Staff Development Coordinator or designee will inservice licensed nursing staff on completing the 24 hour chart checks.</p> <p>Administrative Director of Nursing (ADNS) or designee will condut audits of residents identified as being on fluid restrictions to ensure that fluid restriction is adhered to, no water pitcher at bedside unless accounted for in the Dietician's Fluid Restriction Worksheet and ensure that fluid restriction is transcribed onto the plan of care and TASK. This audit will be daily for two weeks, then weekly for two weeks, then if appropriate monthly for two months,</p> <p>Administrative Director of Nursing ADNS or designee will conduct audits of residents receiving sliding scale insulin coverage before meals to ensure it is administered timely. This audit will be done daily for two weeks, then if appropriate monthly for two months.</p> <p>The Administrative Director of Nursing or designee will conduct audits of residents identified as receiving Xanax to ensure that the physician order for Xanax is accurately transcribed onto the Medication Administration Record and that 24 hour chart checks are completed. This audit will be done daily for two weeks, then weekly for two weeks, then if appropriate monthly for two months.</p>		

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F 309	<p>Continued From page 38</p> <p>documentation system the CNAs only document the percentage of the solids consumed during meals. E19 stated they do not document fluid amounts unless someone is on a fluid restriction and the CNAs do not document that, the nurses do.</p> <p>On 10/14/15 at 4:19 PM, during an interview with E3 (Corporate Nurse), findings were reviewed. E3 stated the facility does not track amounts of fluid residents consume and confirmed that someone on a fluid restriction should not have a water cup at the bedside.</p> <p>On 10/15/15 at approximately 2:00 PM, findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse).</p> <p>2. R453 was admitted to the facility on 9/28/15. The admission orders, dated 9/28/15, included an order for R453 to receive the medication Xanax 0.25 mg every eight (8) hours as needed.</p> <p>An NP Progress Note, dated 10/16/15 and timed 12:28 PM, stated "...Chief Complaint: Somnolence...Nursing reports pt sleeps a lot during day time...Xanax prn, pt sleeps at night, sometimes gets up early, gets anxious at night and uses to take (sic) Xanax...Diagnosis: Acute Somnolence, Plan:...decrease Xanax to .25 mg QHS prn..."</p> <p>A written physician's order, dated 10/16/15 and timed 1:00 PM, stated to change Xanax 0.25 mg by mouth to every day at bedtime as needed for anxiety.</p> <p>Review of a Controlled Substance Prescription Request Form, dated 10/16/15 and completed by</p>	F 309	<p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p>		

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F 309	<p>Continued From page 39</p> <p>the NP, stated "Xanax .25 mg 1 tab (tablet) PO Q HS prn anxiety."</p> <p>A nurse's progress note, dated 10/16/15 and timed 1:13 PM, stated, "seen by NP and new orders noted...make Xanax q hs routine..." This note indicated the medication would be given every evening, contrary to what the order stated. which was for it to be given as needed (prn).</p> <p>Review of the eMAR revealed the 10/16/15 Xanax order was entered as "Xanax tablet 0.25 mg give 0.25 mg by mouth at bedtime for anxiety ." Additionally, there was no evidence that a 24 hour chart check was completed for the 10/16/15 Xanax order. As a consequence, R453 received Xanax at bedtime on 10/16/15 through 10/19/15 whether it was needed or not. Review of nurse's progress notes from 10/16/15 through 10/19/15 lacked any evidence of R453 experiencing any anxiety prior to bedtime.</p> <p>The facility failed to accurately enter a physician's order into the eMAR system and failed to complete a 24 hour chart check resulting in R453 receiving Xanax not according to the physician's orders.</p> <p>Findings were reviewed with E1 and E2 during an interview on 10/20/15 at 12:19 PM.</p> <p>3. R447 had a physician's order for sliding scale coverage with Humalog Insulin, dated 9/30/15, to be given subcutaneously before meals and at bedtime.</p> <p>During the medication pass observation on 10/8/15 at 10:35 AM, R447 was given 4 units of Humalog Insulin approximately 1 1/2 hours after</p>	F 309			

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F 309	Continued From page 40 breakfast (10:35 AM) by E32 (RN). The blood sugar that was covered was done at 7:30 AM. Breakfast trays were observed to be delivered and eaten between 8:30 AM and 9 AM. The facility failed to follow the physician order to give Insulin coverage before meals.  During an interview with E32 on 10/8/15 at 2:35 PM, E32 confirmed the finding and stated her normal practice was to check the blood sugar in the morning and give sliding scale Insulin coverage after ensuring the resident's meal tray was present.  Findings were reviewed with E1 and E2 on 10/22/15 at approximately 3:45 PM.	F 309			
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide to a resident who was unable to carry out activities of daily living, the necessary services to maintain good oral hygiene for one (R171) out of 47 Stage 2 sampled residents. Findings include:  The facility's procedure entitled, "Oral Hygiene and Denture Care", dated 1/2011, stated, "Purpose: To remove plaque and food debris from	F 312	It is the practice of the facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  Resident R171 was provided treatment and is receiving necessary services to maintain good oral hygiene. R171 has a	12/31/15	

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F 312	<p>Continued From page 41</p> <p>teeth and mouth, decrease mouth odor, massage gums and clean tongue and to promote moist lips and mouth... Procedure: ... Oral hygiene is offered as needed... Brushing teeth... Brush teeth using vertical and circular motion... Suggested documentation: Care provided; Unusual observations and/or complaints and subsequent interventions including communications with physician".</p> <p>The quarterly MDS assessment, dated 7/29/15, stated R171 was cognitively intact and required extensive assistance of one person for transfer and hygiene.</p> <p>The care plan entitled, "ADL self care deficit related to physical limitation, parkinsons", last reviewed on 9/21/15, had the goal to participate in self care tasks at the highest practicable level of functioning. Interventions included, assist with daily hygiene, grooming, dressing, oral care and eating as needed.</p> <p>R171 had a dental hygienist consult on 2/12/15 with findings of moderate to heavy plaque, moderate food debris and heavy bleeding of the gums. The dental hygienist consult stated, "Comments: Showed (Name of E9/LPN), mod, heavy bleeding gen; will have CNA follow recommendations below. Need to minimize bacteria in mouth...Recommendations: Please brush gums/teeth/tongue at least once daily for patient. Wipe all gums with large 4 x 4 gauze and antimicrobial rinse".</p> <p>Record review lacked evidence of toothbrushing, wiping of all gums with gauze and antimicrobial mouthwash/rinse.</p>	F 312	<p>scheduled appointment 11/23/15 for denture fitting. Dental recommendations are being done for R171.</p> <p>The Administrative Director of Nursing/ designee will audit dependent residents oral hygiene to ensure they are receiving necessary services to maintain good oral hygiene and that dental consult recommendatons are being reviewed and implemented if appropriate.</p> <p>The Staff Development Coordinator or designee will inservice certified nursing assistant staff on oral hygiene care and licensed nurses are to check oral care during weekly body audits to validate residents oral hygiene is being done.</p> <p>The Administrative Director of Nursing or designee will audit dependent residents oral hygiene to ensure they are receiving necessary services to maintain good oral hygiene and that dental consult recommendatons are being reviewed and implemented if appropriate. This audit will be done daily for one week, then weekly for three weeks, then if appropriate monthly for two months.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).</p>		

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F 312	<p>Continued From page 42</p> <p>On 10/20/15 at 11:20 AM, in an interview, E11 (CNA) stated R171 required morning care today which included mouth care. E11 stated that she brushed R171's teeth with regular toothpaste, brushed her tongue and rinsed her mouth with water. E11 stated that R171's gums were bleeding earlier during mouth care, so she reported it to the nurse. E11 showed the surveyor how she entered into the electronic medical record the care she had provided for R171, and stated toothbrushing was not documented separately since it was part of ADL/morning care.</p> <p>On 10/20/15 at 11:40 AM, R171's mouth was observed to be clean, without food debris or bleeding. R171 was missing lower front teeth and a few teeth on the upper right side.</p> <p>On 10/20/15 at 11:50 AM, in an interview, E10 (CNA) stated she provided care to R171 regularly. E10 stated that more than a month ago, she brushed the resident's teeth and they bled so she decided not to further brush R171's teeth after that and only rinsed her mouth. E10 stated she did not report the bleeding to the nurse. E10 then stated, "To be honest, I didn't always have the mouthwash, the little bottles, I think they're McKesson, and when the mouthwash was not in the room, I would have had to go downstairs to get more, so then I just rinsed the resident's mouth with water". E10 again confirmed that she only rinsed R171's mouth for more than a month without brushing the resident's teeth.</p> <p>On 10/20/15 at 12:45, in an interview, E9 reviewed the 2/12/15 dental services recommendations and stated, "I don't remember reviewing this. I don't know if it just got filed away ". E9 also looked at the electronic medical record</p>	F 312			

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F 312	<p>Continued From page 43</p> <p>including the CNA tasks/kardex, the eTARs from 2/15 forward and the progress notes from 2/1/15 to 2/15/15 and stated the recommendations were not there. E9 further stated toothbrushing was part of ADL/morning care so it was not documented anywhere, however, she would expect, "wipe all gums with large 4 x 4 gauze and antimicrobial rinse" would have been placed on the eTAR to ensure that it was done and then documented as such.</p> <p>On 10/21/15 at 12:10 PM, a list of dayshift CNAs who provided ADL/morning care to R171 from 9/1/15 through 10/21/15 was given to the surveyor. E 10 provided ADL/morning care 34 out of 51 times during that timeframe and according to E10's interview on 10/20/15, she did not brush R171's teeth for more than a month.</p> <p>On 10/21/15 at 12:10 PM, in an interview, E2 (DON) stated she would have expected R171's physician to be advised of the 2/12/15 dental recommendations, a physician's order obtained and the order placed on the appropriate form, for example, CNA tasks, eTAR. E2 confirmed that there was no evidence of facility following up on the dental recommendations.</p> <p>On 10/21/15 at 1:50 PM, in an interview, E5 (DCD) he confirmed the facility used McKesson mouthwash which was not an antimicrobial mouthwash or rinse.</p> <p>The facility failed to provide the necessary services to maintain good oral hygiene for R171, a dependent resident. The facility failed to provide and document oral care as recommended by the dental consult for R171 in February 2015. When mouthwash was used between February and</p>	F 312			

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F 312	Continued From page 44 October, it was not an antimicrobial rinse. There was no evidence that R171's gums were wiped with a large 4 x 4 gauze and antimicrobial rinse. Additionally, for more than a month, E12 did not brush R171's teeth.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/ HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to ensure a resident having pressure sores received the necessary treatment and services to promote healing and to prevent infection for one ( R446) out of 47 Stage 2 sampled residents. Findings include:  R446's clinical record revealed the presence of several pressure ulcers upon admission. A Nurse's Note, dated 10/7/15 at 7:46 AM, stated that R446 had pressure ulcers on his coccyx, left	F 314	It is the practice of the facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  Resident R446 wounds have healed.	12/31/15	

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F 314	<p>Continued From page 45 and right trochanter.</p> <p>During a wound care observation on 10/14/15 at 10:38 AM, E6 (LPN, wound care nurse) and E7 (PT/certified wound specialist) were observed performing dressing changes to R446's three pressure ulcers. His incontinence brief was observed with a blue line at the bottom of it and the surveyor observed a small smear of bowel movement. Upon completion of the pressure ulcer dressing changes, E6 and E7 reapplied the same brief.</p> <p>In an interview, on 10/14/15 at 11:02 AM, E6 stated that a blue line on the incontinence brief was indicative of a soiled brief.</p> <p>On 10/14/15 at 11:11 AM, E6 and E7 placed a new incontinence brief on R446 upon the surveyor's request to inspect the incontinence brief with the blue line.</p> <p>On 10/14/15 at 11:25 AM with E3 (Corporate Nurse) present in R446's bathroom, E7 opened the soiled brief and fecal material was present.</p> <p>The facility failed to ensure staff provided wound care in a clean area, free from fecal material in order to prevent infection.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit on 10/22/15 at approximately 3:40 PM.</p>	F 314	<p>The Administrative Director Nursing Services or designee will conduct a random audit of existing residents with pressure sores to peri area/buttocks to ensure that the staff are providing wound care in a clean area free from fecal material in order to prevent infection.</p> <p>The Staff Development Coordinator will inservice the Wound Care Nurse and Wound Care Team on doing dressing changes in a clean area, free from fecal material in order to prevent infection.</p> <p>The Administrative Director Nursing Services or designee will conduct a random audit of existing residents with pressure sores to the peri area/buttocks to ensure that the staff are providing wound care in a clean area free from fecal material in order to prevent infection. This audit will observe dressing changes on two residents per week for four weeks then if appropriate, monthly times 2.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p>		
F 315 SS=G	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive</p>	F 315		12/31/15	

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F 315	<p>Continued From page 46</p> <p>assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on clinical record reviews, interviews, observations and review of other facility documentation including hospital records, it was determined that the facility failed to ensure that four (R214, R355, R359 and R396) out of 47 Stage 2 sampled residents, who were incontinent of bladder, received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All four residents experienced a decline in continence. For R214, R355, R359 and R396, the facility failed to comprehensively assess their urinary incontinence; failed to complete voiding diaries; failed to individualize toileting plans, resulting in the decline of their urinary continence and for R359, failed to prevent a UTI. Findings include:</p> <p>The facility's guideline (Incontinence Management Practice Guide) entitled, "Ongoing Management Strategies" issue date 3/2012, stated, "Implementing the Bladder Diary will assist in analyzing any voiding patterns as the patient may have. Complete the patterning for at least 3 days on all day (7-3) and evening (3-11) shifts. Voiding records help detect urinary</p>	F 315	<p>It is the practice of the facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Resident R214, R355, and R396 no longer reside at the facility.</p> <p>Resident R359 had a Bladder Patterning and Analysis Worksheet completed; urinary continence assessed and incontinence care plan was revised to include individualized approaches/ interventions.</p> <p>Resident R359 remains free from urinary tract infection.</p>		

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F 315	<p>Continued From page 47</p> <p>patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of incontinence episodes... Risk Factors for incontinence development, Dementia...impaired mobility...aging...". The Guideline failed to include the 11-7 shifts.</p> <p>According to the American Medical Directors Association's (AMDA/The Society for Post-Acute and Long Term Care (LTC) Medicine) Clinical Practice Guideline for Urinary Incontinence stated, ..."Urinary incontinence should be managed, can often be modified, and sometimes be significantly improved or eliminated in frail older adults, including people with dementia who reside in LTC facilities...".</p> <p>Refer to: &lt;<a href="http://www.amda.com/tools/guidelines.cfm">http://www.amda.com/tools/guidelines.cfm</a>&gt;</p> <p>1. Review of R359's record revealed the following :</p> <p>5/21/15 at 10:02 PM- R359 was admitted to the facility from the hospital ED (after an unwitnessed fall from home). The discharge "ED Physician Record" dated 5/21/15 at 8:30 AM indicated that R359 had "no medical concerns...on her laboratory evaluation". The discharge laboratory report called "Urine Studies" dated 5/21/15 at 8:34 AM, did not indicate any findings of urinary tract infection or abnormalities.</p> <p>5/21/15 at 10:02 PM-The facility's "Patient Admission/Readmission Screen" record indicated that R359's "Cognitive Skills for Daily Decision Making were moderately impaired: decisions poor; cues/supervision required". This admission screening indicated that R359 was continent of bladder.</p> <p>The facility initiated a toileting schedule for R359 based on their routine toileting procedures of "</p>	F 315	<p>An initial audit will be conducted by the The Adminstrative Director Nursing Services or designee to identify residents that currently reside in the facility and are identified as frequently incontinent and those identified as having a decline in urinary continence based upon their most recent Material Data Set(MDS).</p> <p>Identified residents will have a Bladder Patterning and Analysis Worksheet initiated and completed; their urinary incontinence assessed and care plans developed/updated to reflect individualized toileting plan/approaches where voiding patterns are identified.</p> <p>Newly admitted residents will have a Bladder Patterning and Analysis Worksheet completed upon admission and if identified as incontinent, type of incontinence will be assessed and an incontinence care plan developed to include individualized approaches/ interventions and revised as needed.</p> <p>Residents that are not identified as frequently incontinent, having a decline in continence or newly admitted will have a Bladder Patterning and Analysis Worksheet completed with their next scheduled Minimum Date Sets (MDs).</p> <p>Staff Development Coordinator or designee will inservice ADNS/IDT on the implementation of the Incontinence Management Practice Guide and use of the Bladder Patterning and Analysis Worksheet.</p>		

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F 315	<p>Continued From page 48 upon awakening, before and after each meal and at bedtime".</p> <p>Review of the CNAs "Toileting" documentation revealed the following:</p> <p>5/23/15 at 2:42 PM, R359 was found incontinent of urine. She was last toileted 5 hours before on 5/23/15 at 9:23 AM. This also indicated that she was not toileted before lunch as per the facility's routine toileting schedule;</p> <p>5/24/15 at 8:34 AM, R359 was found incontinent of urine;</p> <p>5/24/15 at 2:43 PM, R359 was again found incontinent of urine. She was last toileted 6 hours before at 8:34 AM. The toileting documentation did not indicate that R359 was toileted before and after lunch.</p> <p>5/25/15 at 3:45 PM, R359 was found incontinent of urine;</p> <p>5/27/15 at 7:05 AM, R359 was found incontinent of urine;</p> <p>5/27/15- The facility initiated a care plan entitled, "Urinary incontinence related to dementia, impaired mobility. The care plan goals were: "Will have no complications due to incontinence and Will be maintained in as clean and dry dignified state as possible". Interventions included: "Provide assistance with toileting, Provide incontinent care as needed, Report signs and symptoms of UTI..."</p> <p>The care plan lacked goals that included restoration toward R359's normal bladder</p>	F 315	<p>Licensed nursing staff will be inserviced by the Staff Development Coordinator(SDC) or designee on the use of Bladder Patterning and Analysis Worksheet, assessing/incontinence, developing/assessing/revising care plans to include individualized approaches/interventions for urinary incontinence.</p> <p>The Administrative Director Nursing Services/Inter Disiplinary Team will review resident Bladder Patterning and Analysis Worksheet findings at their daily morning meeting and ensure those residents identified as incontinent have had their incontinence assessed and that a care plan has been developed to include individualized approaches/interventions where voiding patterns are identified.</p> <p>The Administrative Director Nursing Services/Inter Disiplinary Team will review MDS triggered incontinence Care Area Assessment's in the daily morning meeting to ensure that a care plan is developed/updated/and/or revised to include individualized approaches/interventions.</p> <p>Staff Development Coordinatorr designee will educate licensed nursing staff on accurately completing the urinary continence portion of the admission/readmission screen.</p> <p>The Administrative Director Nursing Services or designee will conduct audits to ensure that residents identified as</p>		

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F 315	<p>Continued From page 49</p> <p>function or prevention of a decline and a UTI. The care plan also lacked the interventions to implement a voiding diary and to implement a toileting schedule based on the result of that voiding diary.</p> <p>There was lack of evidence in the clinical record that a Voiding Diary was implemented for R359, despite the facility's knowledge of her urinary incontinence episodes.</p> <p>5/28/15 - 14 day Admission MDS assessment identified that R359 was occasionally incontinent of bladder, during the seven (7) day review time period (5/21/15 through 5/28/15) and there was no trial of a toileting program.</p> <p>5/28/15 -14 day admission MDS assessment indicated that R359's diagnoses included Dementia and impaired vision. R359's cognition was severely impaired and needed extensive assist of staff with her ADLs such as transfer, toilet use, dressing, personal hygiene and bathing . She needed one person/staff assist to walk in the room and between locations in her room.</p> <p>The facility was aware that R359 was experiencing incontinence of bladder based on their assessments, (from continent to occasionally incontinent) and care plan, however, the facility lacked documentation that a Voiding Diary was implemented when R359 had episodes of incontinence. The CNAs Toileting documentation showed that the facility proceeded with their routine toileting schedule of "upon awakening, before and after each meals and at bedtime" for R359.</p> <p>The facility failed to analyze R359's voiding</p>	F 315	<p>frequently incontinent or identified as having a decline in continence per the MDS will be reviewed to ensure that a Bladder Patterning and Analysis Worksheet was completed; urinary incontinence assessed and care plan developed to reflect individualized toileting plan/approaches. This audit will be done daily for two weeks, then weekly for two weeks, then if appropriate monthly for two months.</p> <p>The Adminstrative Director Nursing Services or designee will conduct audits on new admissions to ensure that a Bladder Patterning and Analysis Worksheet is completed upon admission and if identified as incontinent, type of incontinence will be assessed and plan of care developed to include individualized approaches/interventions and revised as needed. This audit will be conducted daily for two weeks, then weekly for two weeks, then monthly for two months until 100% compliance achieved.</p> <p>The Adminstrative Director Nursing Services or designee will audit patient admission/readmission screen to validate that the urinary continence portion has been completed and accurately reflects the resident. This audit will be conducted daily for two weeks, then weekly for two weeks, then monthly for two months.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will</p>		

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F 315	<p>Continued From page 50</p> <p>patterns to help detect R359's need for an individualized toileting schedule to reduce or avoid the frequency of incontinence and or intervals between incontinence episodes.</p> <p>Review of R359's nurses' notes revealed the following:</p> <p>5/30/15 -dark yellow urine with strong odor;</p> <p>5/31/15 at 5:00 AM - "toileted with assist of one, urine light orange in color, appears cloudy with strong odor. Specimen for UA/C&amp;S obtained awaiting pick up by the laboratory...."</p> <p>6/1/15 at 6:50 AM- "...patient with some confusion ...restless thru the night...UA sent out for analysis "</p> <p>On 6/1/15 at 1:30 AM, CNAs "Toileting" record stated; R359 was incontinent of urine.</p> <p>On 6/1/15 - A Physician ordered the antibiotic ( Cipro) for R359.</p> <p>6/1/15 - A care plan entitled, "Infection of urinary tract" was initiated. The goal of this care plan was : "Resident's Infection will be resolved without complications". The interventions were: " Administer medication per physician orders; Maintain precautions as indicated; obtain labs as ordered and notify physician results; Record temperature as clinically indicated".</p> <p>It was unclear why, despite these findings, the facility failed to revise the care plan, complete a urinary incontinence evaluation using a voiding diary to individualize a toileting program for R359 as per the facility's guideline.</p>	F 315	determine the need for further audits and/ or a performance improvement plan (PIP).		

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F 315	<p>Continued From page 51</p> <p>6/2/15 - UA &amp; C&amp;S result showed positive for a UTI.</p> <p>6/4/15 - The physician ordered to discontinue Cipro and prescribed a different antibiotic, Macrobid, for 10 days.</p> <p>Review of R359's 6/2015 CNAs "Toileting" documentation revealed that R359 had 28 urine incontinent episodes in 30 days.</p> <p>7/14/15 Nurse's note stated R359 was experiencing lethargy and the physician ordered a UA/C&amp;S.</p> <p>7/15/15 - Result of the UA &amp; C&amp;S indicated that there were few bacteria but had no growth. The physician ordered Macrobid tablets twice a day for R359 for 10 days.</p> <p>Review of R359's 7/2015 CNA "Toileting" documentation revealed that R359 had 38 incontinent episodes in 31 days.</p> <p>8/19/15 -Quarterly MDS assessment stated that R359's cognition was severely impaired and bladder continency was assessed as frequently incontinent. The same MDS stated that despite R 359's frequently incontinent status there was no trial of a toileting program. The record lacked evidence that interventions were put in place to restore or prevent a further decline in R359's bladder function, despite this decline.</p> <p>8/25/15 an 11:16 AM Nurse's note stated " Received verbal order for UA/C&amp;S. R359 has had increased behaviors and tearfulness. Gait is very unsteady..."</p>	F 315			

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F 315	<p>Continued From page 52</p> <p>8/26/15- UA and C&amp;S which resulted in no growth and no new orders.</p> <p>Review of R359's 8/2015 CNAs "Toileting" documentation revealed that R359 had 53 urine incontinent episodes in 31 days.</p> <p>9/2/15 A Physician's order stated Cranberry capsules by mouth twice a day.</p> <p>Review of R359's 9/2015's CNAs "Toileting" documentation revealed that R359 had 40 episodes of urinary incontinence. In addition, the "Toileting" documentation revealed that R359 had no documented record of toileting on the following dates:</p> <p>9/5/15 - 7 AM-3 PM shift from 8:10 AM through 4:59 PM (9hrs). 9/10/15-3 PM-11 PM shift from 3:35 PM through 12:39 AM 9/11/15 (9hrs). 9/13/15 - 7 AM-3 PM shift from 7:36 AM through 3:11 PM (7 1/2 hrs). 9/15/15-7 AM-3 PM shift from 8:35 AM through 4:05 PM (7 1/2 hrs). 9/16/15 - 3 PM-11 PM shift from 3:55 PM through 1:51 AM 9/17/15 (13 hrs). 9/21/15 - 7 AM-3 PM shift from 7:39 AM through 2:24 PM (7hrs). 10/15/15 -1:39 PM through 6:31 PM (5 hrs). 10/17/15 - 3:46 PM through 10/18/2015 at 3:33 AM (11 hrs). It is unclear if R359 had episodes of urinary incontinence between these times.</p> <p>Review of R359's 10/2015 (10/1/15-10/20/15) Toileting documentation revealed 20 urine incontinent episodes in 20 days without</p>	F 315			

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F 315	<p>Continued From page 53 implementation of a voiding diary.</p> <p>Although the facility had an "Incontinence Management Practice Guide", the facility failed to ensure that this system was appropriately implemented for R359 when this resident showed four (4) incontinent episodes that started on 5/23/15 (2 days post admission) and was found to have a UTI on 6/2/15. R359's urinary function declined from being (0) continent on admission, to (1) occasionally incontinent and further declined to being (2) frequently incontinent as per the quarterly MDS assessment dated 8/19/15.</p> <p>This finding was discussed with E3 (Corporate Nurse), and E4 (DCD) on 10/19/15 at approximately 3:40 PM and with E1 (NHA), E2 (DON), and E3 on 10/20/15 at approximately 4:00 PM.</p> <p>This finding was also discussed on 10/22/15 at approximately 4:00 PM during the exit conference with E1 and E2.</p> <p>2. R355 was admitted to the facility on 5/16/15 with diagnoses that included diabetes, depression, chronic pain and idiopathic peripheral autonomic neuropathy.</p> <p>The nursing "Patient Admission/Readmission Screen," and "Nursing Admission Evaluation," both dated 5/16/15, stated R355 was continent of bladder.</p> <p>The 5/18/15 physician's H&amp;P stated R355 was occasionally incontinent of bladder.</p> <p>The 5/23/15 admission MDS assessment stated R355 was independent for daily decision making skills, required extensive assist of one (1) staff for</p>	F 315			

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F 315	<p>Continued From page 54</p> <p>bed mobility, transfer and toilet use. The MDS assessment also stated R355 was occasionally incontinent of bladder during the assessment period (5/17/15 through 5/23/15) and there was no trial of a toileting program.</p> <p>R355's clinical record lacked evidence of a 3 day voiding diary having been completed to determine patterns of incontinence. The facility failed to ensure that a voiding diary was completed and they failed to develop an individualized toileting plan based on the voiding diary for R355.</p> <p>On 5/29/15 a urinary incontinence care plan was developed. One goal of this care plan was "Will attain/maintain continence, based upon usual voiding pattern." Since the facility failed to complete a voiding diary to determine R355's voiding patterns, this goal was not attainable. Interventions included: adjust toileting times to meet patient needs; provide assistance with toileting; and report changes in amount, frequency, color or odor of urine.</p> <p>Review of electronic documentation for "Toileting," completed by CNAs, revealed the following:          - 5/16/15 through 5/31/15 - six (6) documented episodes of incontinence;          - 6/1/15 through 6/30/15 - seven (7) documented episodes of incontinence;          - 7/1/15 through 7/31/15 - approximately 125 documented episodes of incontinence;          - 8/1/15 through 8/14/15 - approximately 77 documented episodes of incontinence.</p> <p>A nurse's note, dated 6/24/15, stated R355 had an appointment on 6/26/15 to receive a lower back injection for pain management.</p>	F 315			

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F 315	<p>Continued From page 55</p> <p>The 60 Day Medicare MDS assessment, dated 7/16/15, stated R355's daily decision making skills were moderately impaired and he required extensive assist of two (2) staff for toilet use. The 7/16/15 assessment also stated R355 was now frequently incontinent during the assessment period (7/10/15 through 7/16/15) and there was no trial of a toileting program. This was a decline from the 5/23/15 MDS assessment, when R355 was occasionally incontinent.</p> <p>The clinical record lacked evidence that R355 was re-evaluated after the urinary continence decline, lacked evidence of care plan revision, lacked evidence of a voiding diary being completed and lacked evidence that the physician was aware of the increase in incontinence and was involved.</p> <p>Review of the clinical record for July, 2015 revealed R355 was experiencing major depression and increased pain. R355 was refusing to get out of bed, refusing therapy, medications, and refusing to eat. Readjustments were being made to antidepressant and pain medications.</p> <p>During an interview on 10/21/15 at 2:15 PM, E29 (CNA) stated that she had cared for R355 regularly during his stay at the facility. E29 stated that initially he improved with therapy but then got worse and for a time wouldn't get out of bed or participate in therapy. E29 stated that initially he used a urinal independently and was continent, but then declined and she would go in every two (2) to three (3) hours to ask if he needed to toilet. E29 stated that they do not do voiding diaries, that they go in every 2 to 3 hours and ask the resident if they need to go or check to see if they</p>	F 315			

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F 315	<p>Continued From page 56 are wet.</p> <p>In an interview on 10/21/15 at 2:25 PM, E30 (COTA) stated the resident had a long history of back pain and had an increase in depression and would not get out of bed for a week, resulting in a significant decline. E30 stated R355 initially made progress but then declined and was not able to tolerate getting on a toilet due to pain.</p> <p>On 10/21/15 at 2:50 PM during an interview, E31 (R355's physician) stated R355 had chronic lower back issues and had back injections several times which can cause irritation of the nerve in the lower back which can then affect bladder function. E31 stated the resident was very depressed and had "given up."</p> <p>The facility failed to ensure that R355, who entered the facility occasionally incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible. There was no initial voiding diary completed and no individualized care plan developed based on the residents' voiding patterns. Although R355 remained mostly continent until July 2015, the 7/16/15-60 Day Medicare MDS assessment stated there was a decline in urinary status to frequently incontinent. The facility failed to re-assess the resident after this decline, failed again to complete a voiding diary to determine voiding patterns, failed to revise the plan of care and lacked evidence that the residents' physician was involved or informed of this decline.</p> <p>Findings were reviewed on 10/21/15 at 4:30 PM with E3 and on 10/22/15 at approximately 4:00 PM during the exit conference with E1 and E2.</p>	F 315			

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F 315	<p>Continued From page 57</p> <p>3. R214 was admitted to the facility on 4/8/15 for short term rehabilitation.</p> <p>4/8/15 timed 9:15 PM - The nursing admission screen stated that R214 was independent with daily decision making, continent of bladder, required assistance for toileting and was ordered diuretic medication.</p> <p>4/15/15 - The admission MDS assessment stated R214 was cognitively intact, occasionally incontinent of bladder and not on a toileting program.</p> <p>Review of R214's clinical record revealed a lack of evidence of a comprehensive assessment of her urinary incontinence, including a bladder diary to determine her voiding pattern. Despite the lack of a comprehensive urinary assessment, the facility care planned R214 for urinary incontinence.</p> <p>4/20/15 - R214 was care planned for urinary incontinence related to loss of bladder muscle tone and impaired mobility. One of R214's goals for her urinary incontinence care plan was to "attain/maintain continence, based upon usual voiding pattern". The care plan approaches included: "remind and assist as needed with toileting at routine times such as upon arising in AM, with meals and at bedtime; adjust toileting times to meet patient needs; provide incontinent care as needed". It was unclear in the clinical record how the facility could meet R214's goal to attain/maintain continence based upon her usual voiding pattern when the facility lacked a comprehensive urinary assessment, including a bladder diary to determine her voiding pattern.</p>	F 315			

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F 315	<p>Continued From page 58</p> <p>The facility failed to individualize the care plan to meet the needs of R214.</p> <p>4/22/15 - The Medicare 14-day MDS assessment stated R214 was occasionally incontinent of bladder.</p> <p>R214 was hospitalized from 4/27/15 to 5/1/15.</p> <p>5/1/15 timed 5:31 PM - The nursing readmission screen stated that R214 was independent with daily decision making, continent of bladder, required assistance for toileting and ordered diuretic medication.</p> <p>R214 was hospitalized from 5/2/15 to 5/13/15.</p> <p>5/13/15 timed 7:05 PM - The nursing readmission screen stated that R214 was independent with daily decision making, continent of bladder, required assistance for toileting and ordered diuretic medication.</p> <p>5/20/15 - The admission MDS assessment stated R214 was cognitively intact and continent of bladder.</p> <p>5/27/15 - The Medicare 14-day MDS assessment stated that R214 was occasionally incontinent of bladder. It was unclear in R214's clinical record how the facility responded when her urinary continence declined and she became occasionally incontinent according to the 5/27/15 MDS assessment. The facility failed to comprehensively assess R214's urinary incontinence when she became occasionally incontinent.</p> <p>R214 was hospitalized from 6/1/15 to 6/17/15.</p>	F 315			

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F 315	<p>Continued From page 59</p> <p>6/17/15 timed 9:06 PM - The nursing readmission screen stated that R214 was independent with daily decision making, continent of bladder, required assistance for toileting and ordered diuretic medication.</p> <p>6/24/15 - The significant change MDS assessment stated that R214 was cognitively intact, frequently incontinent of bladder, required extensive assist of two staff persons for toileting and ordered diuretic medications. The facility failed to comprehensively assess, which included completion of a bladder diary, when R214 was identified as frequently incontinent of bladder. In addition to the lack of a comprehensive urinary assessment, the facility reinitiated the same 4/20/15 urinary incontinence care plan for R214.</p> <p>6/29/15 - R214's care plan for urinary incontinence remained the same. It was unclear in the clinical record how the facility could meet R 214's goal to "attain/maintain continence based upon her usual voiding pattern" when the facility lacked a comprehensive urinary assessment, which included completion of a bladder diary to determine her voiding pattern. The facility failed to individualize the care plan to meet the needs of R214.</p> <p>7/3/15 - The Medicare 14-day MDS assessment stated that R214 was frequently incontinent of bladder. It was unclear in R214's clinical record how the facility responded to her continued frequent incontinence.</p> <p>7/13/15 - The Medicare 30-day MDS assessment stated that R214 was occasionally incontinent of bladder, which was an improvement in urinary</p>	F 315			

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F 315	<p>Continued From page 60 incontinence from the previous assessment.</p> <p>R214 was hospitalized from 7/29/15 to 8/7/15.</p> <p>8/7/15 timed 7:52 PM - The nursing readmission screen stated that R214 was independent with daily decision making, continent of bladder and required assistance for toileting. Upon readmission, R214 was not ordered diuretic medication for the remainder of her stay at the facility.</p> <p>8/14/15 - The admission MDS assessment was cognitively intact and occasionally incontinent of bladder. Although R214's urinary incontinence improved from frequently to occasionally, the facility failed to comprehensively assess, which included completion of a bladder diary.</p> <p>8/21/14 - The Medicare 14-day MDS assessment stated that R214 was occasionally incontinent of bladder.</p> <p>8/26/15 - R214 was discharged from the facility.</p> <p>Review of R214's monthly documentation of urinary incontinence episodes revealed the following: - April 8-27, 2015 - incontinent 6 times; - May 1-2, 2015 and May 13-31, 2015 - incontinent 9 times; - June 17-30, 2015 - incontinent 17 times; - July 1-28, 2015 - incontinent 29 times; and - August 8-26, 2015 - incontinent 5 times.</p> <p>Review of the physician's progress notes during R214's entire stay at the facility from April 2015 through August 2015 lacked evidence of her urinary incontinence.</p>	F 315			

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F 315	<p>Continued From page 61</p> <p>Review of the clinical record revealed that in eight (8) out of nine (9) MDS assessments, R214 was identified as being either occasionally or frequently incontinent of bladder. The facility failed to comprehensively assess her urinary incontinence, which included completion of a bladder diary.</p> <p>In an interview on 10/19/15 at 3:21 PM, E4 (DCD) stated that bladder diaries were not completed for R214 upon admission and three (3) subsequent readmissions to the facility.</p> <p>Findings were reviewed on 10/20/15 at 3:20 PM with E1, E2 and E3. The facility failed to ensure that R214 received appropriate treatment and services to maintain as much normal bladder function as possible.</p> <p>4. R396 was admitted to the facility on 7/15/15 for short term rehabilitation after being hospitalized for sepsis/ E.coli bacteremia, and advanced breast and colon cancers.</p> <p>The nursing admission screen, dated 7/15/15 and timed 6:43 PM, stated that R396 was alert and oriented, continent of bladder, and required assistance for toileting.</p> <p>The admission MDS assessment, dated 7/22/15, stated R396 was cognitively intact, occasionally incontinent of bladder and not on a toileting program.</p> <p>Review of R396's clinical record lacked evidence of a comprehensive assessment for urinary incontinence, including a bladder diary to determine her voiding pattern. Although the 7/22/</p>	F 315			

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F 315	<p>Continued From page 62</p> <p>15 admission MDS triggered the CAAs and was checked to develop a urinary incontinence care plan, review of R396's care plans lacked evidence of a urinary incontinence care plan. It was unclear in the clinical record how the facility could attain/maintain R396's continence based upon her usual voiding pattern when the facility lacked a comprehensive urinary assessment, including a bladder diary to determine her voiding pattern.</p> <p>Review of R396's physician's progress note, dated 7/23/15, stated that R396 had bowel and bladder incontinence.</p> <p>Review of electronic documentation for "Toileting" for R396, completed by CNAs, revealed the following:  - 7/15/15 through 7/31/15 - sixteen (16) documented episodes of incontinence;  - 8/1/15 through 8/31/15 - three (3) documented episodes of incontinence;  - 9/1/15 through 9/11/15 - three (3) documented episodes of incontinence, (urinalysis was negative on 9/8/15).</p> <p>R396 was hospitalized 9/11-9/22/15 for complaints of abdominal discomfort and nausea with dry heaves. R396 was readmitted to the facility on 9/22/15 with diagnoses that included MRSA bacteremia, right hip pain and a history that included metastatic breast cancer, metastatic colon cancer and irritable bowel syndrome.</p> <p>The nursing admission screen, dated 9/22/15 and timed 7:38 PM, stated that R396 was alert and oriented, continent of bladder, and required assistance for toileting.</p>	F 315			

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F 315	<p>Continued From page 63</p> <p>The significant change MDS assessment, dated 9/29/15, stated R396 was cognitively intact, required extensive assistance of two+ staff for toileting, was frequently incontinent of bladder, and was not on a toileting program. Diagnoses included UTI in last 30 days, MDRO and Bacteremia. The 9/29/15 significant change MDS again triggered the CAAs and was checked to develop a care plan for urinary incontinence. However, once again, review of R396's care plans lacked evidence of a urinary incontinence care plan.</p> <p>Review of electronic documentation for "Toileting" for R396, completed by CNAs, revealed the following: - 9/22/15 through 9/30/15 - fourteen (14) documented episodes of incontinence; - 10/1/15 through 10/14/15 at 08:26 AM - nine (9) documented episodes of incontinence [On 10/7/15, R396's physician ordered the diuretic, Lasix 20 mg daily for increased swelling in her legs].</p> <p>During an observation and interview on 10/12/2015 at 2:30 PM, R396, who was alert and oriented, stated that she had "diarrhea since this morning". R396 denied any problems with care in the facility and stated that her pad (disposable brief) was changed a couple of times a day. When asked if she was toileted, she stated, "yes". When asked how she was toileted, with assistance or independently?... R396 stated, "2 person assist" ... with a hooyer lift. R396 stated, "I've had my setbacks... had MRSA... since my admission... was in the hospital for 11 days". R396 was observed in bed with the call bell in reach and no signs or symptoms of urinary incontinence.</p>	F 315			

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F 315	<p>Continued From page 64</p> <p>During an interview on 10/13/15 at 2:50 PM, E4 (DCD) confirmed there was no care plan for incontinence despite the CAAs being triggered on both R396's admission MDS, dated 7/22/15 and significant change MDS, dated 9/29/15. The decision to care plan for urinary incontinence had been checked as "yes" on both CAAs. E4 denied completion of a 3 day voiding diary or full bladder assessment for R396. E4 stated that R396 was alert and oriented, able to use the call bell and make her needs known. She stated that the resident currently uses a bedpan and has been toileted per the facility, "Standard times of upon arising, around meal times and at bedtime and as needed per the resident's request". E4 was unable to state what type of incontinence R396 had. She stated she would interview R396 to determine the type of incontinence and if she could identify any other problems. E4 stated she would then initiate an incontinence care plan.</p> <p>On 10/13/15 at 3:32 PM, R396 was observed neatly groomed, with no signs or symptoms of incontinence, with her call bell in reach, and was interviewed regarding an increase of incontinence . R396 stated that since she was hospitalized, she returned more tired. R396 stated she used her call bell to request/use the bedpan. R396 denied any problems with care and stated that her call bell was answered timely. R396 stated that she was offered a bedpan or was changed when she got up in the morning during morning care, around lunch and dinner times and at bedtime. She denied any incontinence at night. R 396 denied the need for additional toileting times and stated being "satisfied with her care".</p> <p>Findings were reviewed on 10/20/15 at approximately 3:35 PM with E1, E2, E33 (ADON),</p>	F 315			

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F 315	Continued From page 65 E3 and E34 (Regional Therapist). When asked if R214, R359 or R396 had been seen by therapy for incontinence, E34 stated, "No, none of these 3 residents". The facility failed to ensure that assessment, monitoring, reviewing, and revising approaches to care (as needed) were done to manage R396's urinary incontinence and to restore as much normal bladder function as possible upon her 7/15/15 admission and 9/22/15 readmission, when R396 had a decline in urinary incontinence (from occasionally incontinent to frequently incontinent). Additionally, the facility failed to utilize the facility guideline (which included completing a 3 day voiding diary) and failed to have an incontinence policy and procedure in place.	F 315			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, it was determined that the facility failed to ensure the environment was free from accident hazards in the Arcadia wing dining room and four rooms ( 128,152,155,177) out of 39 rooms surveyed. Findings include:  1. During dining observations on 10/8/15 at	F 323	It is the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.  1. The electric box that controls the	12/31/15	

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F 323	<p>Continued From page 66</p> <p>approximately 12:25 PM, an electric oven was observed inside of the dining room in the Arcadia dementia locked unit. Upon further investigation, the oven was plugged in and working properly. The electrical box that controls the power for the oven was not secured. Lastly, the door to the entrance of the dining room was not capable of being locked and this was confirmed by E13 (CNA). This presented an accident hazard.</p> <p>E14 (Activity Director) was interviewed on 10/8/15 at 4:00 PM. According to E14, the oven was used for baking cookies for the residents on Thursdays. Furthermore, the facility discovered the lock for the switch was missing around 2:15 PM, and they promptly replaced the lock. So only staff with accessibility to the key could turn the power on. E14 confirmed the facility lacked accountability measures to ensure the security of the oven, nor did he have the key for the old lock.</p> <p>Surveyors confirmed the presence of the new lock securing the electric oven on 10/8/15 at 4:30 PM.</p> <p>E15 (Activity Aide) was interviewed on 10/13/15 at 9:43 AM in regards to the oven. E15 stated that the oven was secured when not in use and to turn on the oven E15 must retrieve the key from E14's office. After use, the electrical switch was to be turned off and locked, then the key would be returned upstairs to E14's office. E15 stated she was not aware of a key sign out sheet.</p> <p>E16 (Activity Aide) was interviewed on 10/14/15 at 10:20 AM. According to E16, E15 saw the missing lock several weeks ago and discussed the issue with her. E16 was unable to state the exact date. E15 and E16 decided to inform E14.</p>	F 323	<p>power of the oven is secured.</p> <p>The Activities Director or designee has completed daily audits of the electric box to ensure that it is secured.</p> <p>Staff Development Coordinator or designee will inservice the activities staff on making sure that the electric box is secured after use. A sign in and out form for the key has been implemented.</p> <p>The Activities Director or designee will conduct a daily audit of electric box to make sure that it is secured for daily for 3 weeks then weekly for 2 weeks then if appropriate monthly times 2.</p> <p>Audit results will be forwarded to the Quality Assurance Performance Improvement ommitteend further action if needed.</p> <p>2. The dry wall in room 152 will be repaired.</p> <p>3. The toilet seat missing bumperin room 155 has been replaced.</p> <p>4 and 5. The toilet bolts have been replaced in rooms 128 and 177.</p> <p>The Maintenance Director or designee will conduct an audit of resident rooms to determine that they are free of accident hazards.</p>		

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F 323	<p>Continued From page 67</p> <p>E15 was interviewed again on 10/14/15 at 10:25 AM. According to E15 the missing lock was discovered over 1 month ago at the start of her employment.</p> <p>E14 was interviewed on 10/14/15 at 10:30 AM and confirmed the lock for the electrical switch was missing since it was reported by E15 over 1 month ago.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON) on 10/22/15 at approximately 3:30 PM.</p> <p>During the environmental tour on 10/14/15 between 1:00 PM and 2:30 PM with E1 and E17 (FMD) revealed the following:</p> <ol style="list-style-type: none"> <li>2. Dry wall was exposed in the bathroom for room 152.</li> <li>3. The toilet seat bumper was missing on the bottom of the toilet seat for room 155. The missing bumper could cause the seat to slip. Also, the toilet bolts were rusted and exposed.</li> <li>4. Toilet bolts were rusted and exposed for room 128.</li> <li>5. Toilet bolts were rusted and exposed for room 177.</li> </ol> <p>Findings were confirmed with E1 and E17 on 10/14/15 during the environmental tour.</p> <p>Findings were reviewed with E1 and E2 on 10/22/15 at approximately 3:30 PM.</p>	F 323	<p>The Staff Development Coordinator/ Designee will inservice on identifying and reporting into the electronic TELS system or writing on the 24 hour report any maintenance or environmental issues that need attention. These issues will be reviewed and monitored for completion in the facility's daily morning meeting.</p> <p>The Maintenance Director or designee will conduct an audit of resident rooms to determine that they are free of accident hazards. This audit will be conducted daily for two weeks. then weekly for two weeks, then monthly for two months.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).</p>		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - PIKE CREEK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5651 LIMESTONE ROAD WILMINGTON, DE 19808</b>		
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F 329	<p>Continued From page 69</p> <p>daily dose of Xanax was not exceeded. For R453, the facility failed to implement non-pharmacological interventions prior to use of Xanax on multiple occasions and/or they failed to identify the need for use of the medication. Findings include:</p> <p>1. R453 was admitted to the facility on 9/28/15. The admission orders, dated 9/28/15, included an order for R453 to receive the antianxiety medication Xanax 0.25 mg every eight (8) hours as needed.</p> <p>The eMAR revealed Xanax was administered as follows:</p> <ul style="list-style-type: none"> <li>- 9/30/15 at 3:45 AM - "agitated and restless"; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/2/15 at 7:38 AM - "states feels shaky"; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/2/15 at 7:15 PM - no indication for use found; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/4/15 at 2:46 AM - "c/o anxiety"; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/5/15 at 10:52 PM - "c/o anxiety"; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/14/15 at 12:03 AM - "c/o being anxious"; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/14/15 at 10:32 PM - "c/o restlessness"; no evidence non-pharmacological interventions implemented prior to use;</li> <li>- 10/15/15 at 9:18 PM - "patient requested"; no evidence non-pharmacological interventions implemented prior to use.</li> </ul>	F 329	<p>Resident R453 no longer resides at the facility.</p> <p>Administrative Director of Nursing Services or designee will conduct an audit to identify residents receiving Xanax and ensure that they have an indication for use noted.</p> <p>Administrative Director of Nursing Services /designee will review plan of care for residents identified as receiving prn Xanax to ensure non pharmacological interventions are appropriate for resident and attempted prior to the administration of prn Xanax.</p> <p>Administrative Director of Nursing Services/ designee will identify residents on Xanax that have new or increased signs/symptoms of anxiety to evaluate that behaviors are documented in progress notes and physician notified.</p> <p>Staff Development Coordinator or designee will educate licensed nursing staff to document on residents experiencing new or increased signs and symptoms of anxiety and to place residents on 24 hour report for review and follow up at the facility's daily morning meeting.</p> <p>Staff Development Coordinator or designee will educate licensed nursing staff of need to attempt non pharmacological interventions prior to administering prn Xanax to include but not limited to psychology.</p>		

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F 329	<p>Continued From page 70</p> <p>The facility failed to implement non-pharmacological interventions prior to use of the medication Xanax on multiple occasions and they failed to have an indication for use on one (1) occasion.</p> <p>On 10/20/15 at 12:19: PM, findings were reviewed with E1 (NHA) and E2 (DON).</p> <p>2a. R69 was admitted to the facility on 9/17/15. The admission orders, dated 9/17/15, included an order for Xanax 0.5 mg twice a day as needed for anxiety.</p> <p>Review of hospital discharge records, dated 9/17/15, revealed R69 was taking Xanax 0.5 mg twice daily as needed at home prior to the hospitalization.</p> <p>The facility developed a care plan on 9/18/15 for the problem "episodes of anxiety." Interventions included "Engage in relaxation techniques such as massage, breathing, guided imagery, or one on one, before medicating" and "Identify and decrease environmental stressors."</p> <p>The eMAR revealed Xanax was administered as follows: - 9/18/15 at 3:55 AM - no indication for use identified; no evidence non-pharmacological interventions implemented prior to use; - 9/18/15 at 8:52 PM - "pt's request"; no evidence non-pharmacological interventions implemented prior to use; - 9/19/15 at 8:00 PM - no indication for use identified; no evidence non-pharmacological interventions implemented prior to use; - 9/20/15 at 6:20 AM - no indication for use</p>	F 329	<p>Administrative Director of Nursing Services or designee will meet with facility's physicians and physician extenders to ensure that they understand that when increasing prn Xanax, a note is required justifying the use of a higher dose and that it was necessary to maintain or improve resident function.</p> <p>Staff Development Coordinator or designee will educate licensed nursing staff on the need for prn Xanax to have an indication for use.</p> <p>Administrative Director of Nursing Services or designee will conduct audits of residents identified as receiving prn Xanax to ensure that they have an indication for use.</p> <p>Administrative Director of Nursing Services or designee will conduct audits on residents identified as receiving prn Xanax to evaluate that non pharmacological interventions are appropriate and have been attempted prior to Xanax administration.</p> <p>Administrative Director of Nursing Services or designee will conduct audits on residents identified as receiving prn Xanax to ensure that new or increased signs/symptoms of anxiety/behaviors are documented in progress notes.</p> <p>Administrative Director of Nursing Services or designee will conduct audits on residents identified as receiving prn</p>		

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F 329	<p>Continued From page 71</p> <p>identified; no evidence non-pharmacological interventions implemented prior to use; - 9/20/15 at 9:29 PM - no indication for use identified; no evidence non-pharmacological interventions implemented prior to use; - 9/21/15 at 6:23 AM - no indication for use identified; no evidence non-pharmacological interventions implemented prior to use; - 9/21/15 at 10:37 PM - received Xanax 0.5 mg 2 tablets (1 mg) one time only for insomnia; no documented evidence of need for use and no evidence non-pharmacological interventions implemented prior to use.</p> <p>The facility failed on multiple occasions to implement non-pharmacological interventions prior to use of the medication Xanax and they failed to have an indication for use.</p> <p>2b. R69's admission orders, dated 9/17/15, included an order for Xanax 0.5 mg twice a day as needed for anxiety.</p> <p>Review of hospital discharge records, dated 9/17/15, revealed R69 was taking Xanax 0.5 mg twice daily as needed at home prior to the hospitalization.</p> <p>Review of nurse's progress notes from 9/17/15 through 9/21/15 lacked evidence that R69 was having increased episodes of anxiety.</p> <p>A psychological Diagnostic Interview, dated 9/19/15, stated "...Has a history of depression with anxiety but feels stable on current medications. Denies sleep or appetite problems..."</p> <p>On 9/21/15, the physician checked off twice on the H&amp;P form that R69 was not having any issues</p>	F 329	<p>Xanax to review that prior to increasing prn Xanax dosage, the physician or physician extender has documented behaviors noted and that the use of a higher dose is necessary to maintain or improve resident's function.</p> <p>These audits will be conducted daily for two weeks, then weekly for two weeks, then if appropriate monthly for two months</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p>		

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F 329	Continued From page 72 with anxiety.  A physician's order, dated 9/21/15 and timed 8:15 PM, stated the clarification order for Xanax should be 0.5 mg twice a day + 1.0 mg at HS.  The 9/21/15 Xanax order increased the total daily dose to 2.0 mg per day, despite there being no evidence that R69 was experiencing increased signs or symptoms of anxiety. Additionally, there was no physician's note justifying that use of the higher dose was necessary to maintain or improve R69's function.  On 10/20/15 at 12:19 PM, findings were reviewed with E1 and E2.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview it was determined that the facility failed to ensure that one (R374) out of 47 stage 2 sampled residents were free from significant medication errors. The facility failed to hold R374's Coumadin (blood thinning medication) as indicated and it was incorrectly administered when outside of physician ordered parameters and the facility failed to notify the physician of the corresponding INR results. Findings include:  1a. R374 was admitted to the facility on 6/12/15.	F 333	It is the practice of the facility to ensure that residents are free of any significant medication errors.  Resident R374 no longer resides in the facility. The Administrative Director of Nursing Services (ADNS) or designee will conduct an audit to identify residents that currently reside in the facility receiving Coumadin and have PT/INR orders.  The Staff Development Coordinator or	12/31/15	

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F 333	<p>Continued From page 73</p> <p>R374's physician orders, dated 6/12/15, included Coumadin 2.5 mg by mouth at bedtime; hold for INR &gt; 3.0.</p> <p>On 6/15/15 the facility developed an anticoagulant therapy care plan that included the goal "will maintain lab values in therapeutic range " and INR every Monday and Thursday. Interventions included, "Administer (Coumadin) per physician orders, obtain labs as ordered and notify physician of results...".</p> <p>R374's INR on 6/18/15 was 3.1. Although there was a physician order already in place to hold the Coumadin for INR &gt; 3.0, according to the June 2015 MAR the facility incorrectly administered Coumadin on 6/18/15 when it should have been held.</p> <p>Additionally, review of NN's for 6/18/15 lacked evidence that the physician was notified of the 6/18/15 INR result.</p> <p>b. R374's INR on 7/2/15 was 4.0. R374 had a parameter to hold Coumadin for INR &gt; 3.0 previously. Review of the July 2015 MAR revealed that the facility administered Coumadin on 7/2/15 despite having an abnormally high INR.</p> <p>E21 (NP) examined R374 at 12:31 PM on 7/2/15. The INR result for 7/2/15 was reported to the facility at 3:18 PM. NN's lacked notification of the physician or NP of the 7/2/15 INR.</p> <p>The facility failed to notify the physician of R374's INR on 6/18/15 and 7/2/15 to obtain new orders and facility staff failed to recognize that the Coumadin should have been held.</p>	F 333	<p>designee will inservice licensed staff on Coumadin administration to include knowing when to hold medication, adhering to physician ordered Coumadin therapeutic parameters, and notifying physician of corresponding INR results when out of therapeutic range for new orders.</p> <p>Adminstrative Director of Nursing Services or designee will conduct audits of residents identified as receiving Coumadin and have PT/INR levels drawn to ensure that they are receiving Coumadin dosing as ordered, INR levels are doucmented and within thererapeutic parameters and if in non-therapeutic parameters present, physician is notified. This audit will be conducted daily for two weeks, then weekly for two weeks, then if apporprate monthly for two months:</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).</p>		

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F 333	Continued From page 74 Findings were reviewed and confirmed with E2 (DON) and E3 (Corporate Nurse) on 10/22/15 at 11 AM.	F 333			
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store and dispose of garbage properly. Findings include:  During the initial kitchen tour on 10/8/15 at 9:00 AM, the dumpster door was observed to be open and the refuse storage area was dirty.  During the full kitchen survey on 10/8/15 at 2:50 PM, the dumpster door was again observed open and the refuse storage area was dirty.  Findings were confirmed with E18 (FSD) on 10/8/15 at 9:00 AM.  Findings were reviewed with E17 (FMD) on 10/14/15 at 2:30 PM during the environmental tour.  Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/15 at approximately 3:30 PM.	F 372	It is the practice of the facility to store and dispose of garbage properly.  The Dumpster door is closed and the surrounding area is clean.  The Maintenance Director /designee has conducted daily audits to ensure that the Dumpster is closed and the area is clean.  The Staff Development Coordinator/ Designee will in-service the Food Service staff, Maintenance staff and the Housekeeping staff on keeping the Dumpster Door closed and the area clean.  The Maintenance Director/ designee will conduct daily audits of the Dumpster and surrounding area daily for one week, then weekly for 3 weeks and then if appropriate monthly time 2 months.  Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for	12/31/15	

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F 372	Continued From page 75	F 372			
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, it was determined that the facility failed to ensure dental services were obtained to meet the needs of a resident for one (R171) out of 47 Stage 2 sampled residents regarding a partial lower denture. Findings include:</p> <p>Review of R171's medical record revealed: the initial mobile dental service consult, dated 7/3/14, revealed R171 was seen by the dentist and the "Report Comments", stated, "Pt. said she came into this facility with both upper &amp; lower partial (dentures) - 'lost both'. Recommend a partial lower (denture) only".</p> <p>On 8/22/14, the mobile dentist service faxed a request to the facility for an "Approved signature for Billing Payment" regarding a partial lower</p>	F 412	<p>further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p> <p>It is the practice of the facility to provide or obtain dental services to meet the needs of each resident.</p> <p>Resident R171 has a scheduled appointment to have her partial dentures fitted on 11/23/15. The Minimum Data Services assessment has been corrected.</p> <p>The Adminstraitve Director Nursing Services or designee will conduct an audit of residents who have had dental consults to ensure dental service and/or recommendations were obtained to meet the needs of the residents.</p> <p>The Staf Development Corrdinator or designee will inservice the licensed</p>	12/31/15	

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F 412	<p>Continued From page 76</p> <p>denture to be made for R171. This form had checked areas for the facility to complete but remained blank.</p> <p>The quarterly MDS assessment, dated 7/29/15, stated R171 was cognitively intact, required extensive assistance of one person for transfer, hygiene and was checked "no" for both broken or loosely fitting full or partial dentures and discomfort or difficulty with chewing.</p> <p>Review of R171's progress notes, on 8/14/15 at 9 :25 AM, revealed a quarterly note by E25 ( Activities Director) which stated R171, "...Has confusion but is able to communicate with staff ...".</p> <p>On 10/20/15 at 11:40 AM, an observation was made of R171's mouth which was missing lower front teeth and a few teeth on the upper right side . During that time, R171 stated that she wanted to have the lower partial denture replaced.</p> <p>On 10/21/15 at 12:10 PM, in an interview, E2 ( DON) stated that there was no evidence that the facility followed up regarding a partial lower denture for R171. E2 stated either the DCD or SS could have followed up.</p> <p>On 10/21/15 at 1:30 PM, in an interview E1 (NHA) stated that she reviewed the concern logs and there were no concerns all the way back to 2013 regarding dental/partial plates for R171. E1 gave the surveyor a copy of the billing which only showed the dental payment for R171's 7/3/14 exam. E1, also, stated that either SS or DCD could have followed up regarding R171's partial lower denture. As a follow up to the interview, E1 stated that the faxed request to the facility, sent</p>	F 412	<p>nursing staff on ensuring dental service consults that are obtained are followed up with to meet the needs of the residents.</p> <p>The Adminstraitve Director Nursing Services or designee will conduct an audit of residents who have had dental consults to ensure dental service and/or recommendations were obtained to meet the needs of the residents. This audit will be weekly for three weeks and then if appropriate monthly for two months.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).</p>		

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F 412	Continued From page 77 on 8/22/14, went to the Arcadia unit, not the second floor. E1 stated she did not know how it got to the second floor. E1 stated she also spoke to E22 (SS) who told her that she, E22, did not know anything about the dental request to have a partial lower denture made for R171.  On 10/21/15 at 1:50 PM, in an interview, E5 (DCD ) stated that he did not remember back that far but E5 agreed that there was no evidence in R 171's clinical record regarding any follow up to obtain a partial lower denture for the resident.  The facility failed to follow up regarding dental services for a partial lower denture to be made for R171 in 8/2014.	F 412		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		12/31/15

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F 441	<p>Continued From page 78</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on staff interviews and review of the facility's infection control manual and monthly documentation, it was determined that the facility failed to maintain an effective infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings include:</p> <p>The facility's infection control manual, dated 5/2013, stated under "Monthly Surveillance - Information about infections is gathered, monitored and tracked throughout the month. The information is reviewed by the Infection Preventionist for trend identification including trends that may require initiating outbreak investigations...The monthly Surveillance Summary Report is completed at the end of each month...There are two rate calculations...to</p>	F 441	<p>It is the facility practice to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>Residents residing in the facility that have been identified as meeting criteria for either community acquired infections or healthcare acquired infections have been identified on the monthly infection surveillance log. Data from infection control surveillance log has been compiled into a complete and accurate monthly surveillance summary report and all data contained within has been analyzed to include mapping of infections, identification of clusters and identification</p>	

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F 441	<p>Continued From page 79</p> <p>represent infection trends over time...percentage of patients with infection... and rate of infection... The Infection Preventionist identifies cluster activity through the process of infection mapping. Infection mapping utilizes a floor plan diagram of the center where the infections are 'mapped' on the floor plan...Causative factors are investigated and infection control practice changes to decrease infection rates are recommended as a part of trend analysis...Trend analysis is completed after data is collected on the Infection Control Surveillance Log and entered in the Monthly Surveillance Summary Report...The Infection Preventionist...review the trends, identify root cause and prepare recommendations...may include educational initiatives...skills retraining or skills validation such as hand hygiene, treatment techniques...equipment or supply review...supply availability...".</p> <p>Review of the facility's infection control program from November 2014 through September 2015 revealed the following:</p> <p>November 2014, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to map infections to identify clusters; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>December 2014, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to have a complete and accurate monthly infection surveillance summary report;</li> <li>- failed to map infections to identify clusters; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>January 2015, the facility</p>	F 441	<p>of trends. The facility monthly infection reports will be completed 45 day after the end of the month the log was initiated. For example October 2015 will be completed no sooner than Decemebr 15th 2015.</p> <p>The Adminstraitve Director Nursing Services/designee will conduct an audit on residents identified as meeting criteria for both community acquired infections and healthcare acquired infections to ensure that they are reflected on the monthly infection surveillance log and that the log is complete and up to date.</p> <p>The Adminstraitve Director Nursing Services or designee will conduct an audit to ensure that resident data contained on the monthly infection surveillance log has been accurately compiled and captured on the monthly surveillance summary report and that all data has been analyzed to include mapping of infections, identification of clusters and identification of trends.</p> <p>The Quality Assurance Consultant has inserviced The Adminstraitve Director Nursing Services/Infection Preventionist/ Directors of Care Delivery on the infection control manual and it's requirements.</p> <p>The Adminstraitve Director Nursing Services or designee will review monthly infection surveillance log weekly to review that residents with a CA or HAI infections are listed on the Infection Surveillance log,</p> <p>The Adminstraitve Director Nursing</p>	

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F 441	<p>Continued From page 80</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to have a complete and accurate monthly infection surveillance summary report; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>February 2015, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to map infections to identify clusters; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>March 2015, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to have a complete and accurate monthly infection surveillance summary report; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>April 2015, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to have a complete and accurate monthly infection surveillance summary report; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>May 2015, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to have a complete and accurate monthly infection surveillance summary report;</li> <li>- failed to map infections to identify clusters; and</li> <li>- failed to analyze the data and identify trends.</li> </ul> <p>June 2015, the facility</p> <ul style="list-style-type: none"> <li>- failed to complete the monthly infection surveillance log;</li> <li>- failed to have a complete and accurate monthly infection surveillance summary report; and</li> </ul>	F 441	<p>Services or designee will review monthly surveillance summary report ensuring that monthly infection surveillance log data is accurate and complete, has been analyzed, infections have been mapped out, and clusters and trends identified.</p> <p>The Administrative Director Nursing Services or designee will audit monthly infection surveillance log to ensure that residents identified with healthcare acquired infections and community acquired infections are reflected and that log is completed weekly for four weeks, then if appropriate monthly for two months</p> <p>The Administrative Director Nursing Services or designee will audit monthly surveillance summary report to ensure that data contained on the monthly infection surveillance log is accurately compiled and captured on the monthly surveillance summary report and that its data has been analyzed for mapping of infections and identification of any trends and clusters. This audit will be monthly for three months then if appropriate one more month.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/or a performance improvement plan (PIP).</p>	

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F 441	Continued From page 81 - failed to analyze the data and identify trends.  July 2015, the facility - failed to complete the monthly infection surveillance log; - failed to have a complete and accurate monthly infection surveillance summary report; and - failed to analyze the data and identify trends.  August 2015, the facility - failed to complete the monthly infection surveillance log; and - failed to analyze the data and identify trends.  September 2015, the facility - failed to have a complete and accurate monthly infection surveillance summary report.  In a combined interview on 10/20/15 at 8:31 AM, E12 (SD/IC) stated that she was assigned the infection control program one week ago and the staff person who was previously in charge of the infection control program was no longer at the facility. While reviewing and discussing the above discrepancies in the facility's monthly infection control program from November 2015 through September 2015, E2 (DON) confirmed the findings. E2 also stated there must be a problem with the computer application as to the dates on the monthly logs and the inaccuracies of the monthly summary reports.  The facility failed to maintain an effective infection control program from November 2014 through September 2015, a total of 11 months.	F 441		
F 456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		12/31/15

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F 456	<p>Continued From page 82</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observations, it was determined that the facility failed to maintain all essential kitchen equipment in safe operating condition. Findings include:</p> <p>On 10/8/15 at 2:42 PM, the walk-in refrigerator in the main facility kitchen had a malfunctioning external thermometer.</p> <p>Finding was confirmed with E18 (FSD) on 10/8/15 at 2:43 PM.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/15 at approximately 3:30 PM.</p>	F 456	<p>It is the practice of the facility to maintain all essential equipment in a safe operating condition.</p> <p>The External Thermometer on the walk-in refrigerator is now working.</p> <p>The Food Service Director/Designee will audit the outside Thermometer to ensure it is working.</p> <p>Staff Development Coordinator/ Designee will in-service the Dietary staff on notifying Maintenance when equipment is not working such as the External Thermometer to put in TELS and or on the 24 hour report.</p> <p>The Food Service Director/Designee will audit the outside thermometer to ensure it is working daily for 2 weeks then if appropriate monthly times 2.</p> <p>Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).</p>		

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F 514 F 514 SS=D	Continued From page 83 483.75(l)(1) RES RECORDS-COMplete/ ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that the facility failed to ensure that clinical records for one (R69) out of 47 Stage 2 sampled residents, were complete and accurately documented in accordance with accepted professional standards and practices. Findings include:  Review of R69 clinical record lacked evidence of any psychological consults.  During an interview with E1 (NHA) on 10/20/15 at approximately 2:10 PM, she stated R69 had been seen by a psychologist and provided a list with R 69's name on it from 9/19/15. E1 stated they would contact the psychologist for a copy of the evaluation note. Subsequently a copy of the 9/19/15 psychology evaluation note was provided to the surveyor.	F 514 F 514	It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  Resident R69 clinical record is complete with the psychology evaluation.  The Adminstraitve Director Nursing Services or designee will audit residents seen by the psychologist to make sure the evaluation is in the clinical record.  The Staff Development Coordinator or designee will inservice nursing staff and medical records staff on the need to have psychology evaluations maintained in the clinical record.	12/31/15

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F 514	Continued From page 84 The facility failed to ensure that R69's clinical record was completed when there was no psychology evaluation note in the chart.  Findings were reviewed on 10/22/15 at approximately 3:45 PM during the exit conference with E1 and E2 (DON).	F 514	The Adminstraitve Director Nursing Services or designee will audit residents seen by the psychologist to make sure the evaluation is in the clinical record. This audit will be weekly for three weeks, then if appropraite monthly for two months.  Results of the audits conducted will be forwarded to the Quality Assurance and Improvement (QAPI) Committee for further review. The QAPI Committee will determine the need for further audits and/ or a performance improvement plan (PIP).	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/ MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify	F 520		12/31/15

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F 520	<p>Continued From page 85 and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on clinical record reviews, interview and review of facility documentation, it was determined that the facility failed to identify issues for four (4) (R214, R355, R359 and R396) out of 47 Stage 2 sampled residents, in which quality assessment and assurance activities were necessary and to develop and implement appropriate plans of action to correct identified quality deficiencies related to bladder incontinence. Findings include:</p> <p>Cross refer F315, examples 1, 2, 3 and 4 During an interview with E1 (NHA), E2 (DON), E 12 (SD/IC) on 10/22/15 at 2:00 PM, and review of QAA (Quality Assessment and Assurance) meeting sign up sheets quarterly, the facility had an ongoing QAA committee that met at least quarterly to identify quality deficiencies to ensure that care practices were consistently applied.</p> <p>The facility failed, however, to ensure that quality deficiencies were identified for R214, R355, R359 and R396. Specifically, the facility failed to comprehensively assess all four residents' urinary incontinence; failed to complete voiding diaries; failed to individualize toileting plans, resulting in the decline of their urinary continence; and failed to prevent UTI for R359.</p> <p>The QAA committee failed to identify, develop and implement appropriate plans of action to correct the identified quality deficiencies to ensure that care practices were consistently</p>	F 520	<p>It is the practice that the facility maintain a quality assessment and assurance committee (QAPI) consisting of The A Administrative Director of Nursing Services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>The quality assessment and assurance committee (QAPI) will be inserviced the the Quality Assurance Consultant on the QAA guidelines and process which will include identifying issues and developing, reviewing and revising the performance improvement plans (PIPS) and audit tools as necessary to correct the areas identified.</p> <p>An Adhoc quality assessment and assurance committee (QAPI) Committee meeting will be held to review the audits and Performance Improvement Plans (PIP) from the previous QAPI meeting and will include a weekly subcommittee review to identify any areas the facility has not captured on a PIP or audit tool and</p>	

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F 520	Continued From page 86 applied to maintain as much normal bladder function as possible and prevent UTIs. This finding was discussed with E1, E2 on 10/22/15 at approximately 4:00 PM.	F 520	revising PIP's and audit tools as necessary.  The Quality Assessment and Assurance Committee (QAPI) policies and procedures will be reviewed and the Committe Members will be in-serviced on the facility's policy and procedure for Quality Assessment and Assurance Commitee (QAPI).  The facility will implement a weekly sub-committe to monitor Quality Assessment and Assurance Commitee (QAPI) tools/ audits to identify areas are being captured and revising audit tools as necessary.		