

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

PRINTED: 08/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>17500 W 119TH STREET OLATHE, KS 66061</b>		
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F 000	INITIAL COMMENTS	F 000			
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate 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>	F 278			

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

TITLE

(X6) DATE

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

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F 278	<p>Continued From page 1</p> <p>The facility identified a census of 46 residents. The sample included 17 residents. Based on observation, interview, and record review, the facility failed to conduct a comprehensive, accurate, individualized assessment that addressed the resident's needs and strengths for two residents (#33, #6) of 17 residents reviewed for comprehensive assessments.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of resident #33's physician order sheet dated 5/04/16 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion) and a history of falling.</li> </ul> <p>The admission Minimum Data Set (MDS) dated 5/13/16 documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The resident required supervision with set-up help only for locomotion on and off of the unit. The assessment documented the resident had exhibited wandering behavior for 4-6 days during the lookback period and was at significant risk of getting to a potentially dangerous place.</p> <p>The Care Area Assessment (CAA) for cognitive loss/dementia, behavioral, and activities of daily living dated 5/13/16 indicated the resident had dementia and for staff to encourage independence as much as he/she was able.</p> <p>The care plan dated 5/25/16 indicated the resident had a self care deficit related to dementia and directed staff to provide limited assistance with activities of daily living and to use a walker with ambulation. The care plan lacked</p>	F 278			

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F 278	<p>Continued From page 2</p> <p>documentation the resident was at risk of wandering behavior.</p> <p>During the survey, the facility provided a list of residents who had a WanderGuard (a bracelet that sets off an alarm when residents wearing one attempt to exit the facility without an escort). The resident was not identified by the facility to have a WanderGuard in place.</p> <p>A progress note dated 5/05/16 at 3:49 P.M. documented the resident was adjusting to the new room, environment, and had a WanderGuard on his/her left wrist.</p> <p>A progress note dated 8/10/16 at 4:08 P.M. documented the resident was alert and oriented and was independent with a wheeled walker for ambulation.</p> <p>The progress notes lacked documentation the WanderGuard had been removed or that the resident had demonstrated wandering or exit-seeking behaviors.</p> <p>Review of the Admission Wandering Screening dated 5/5/16 identified the resident's classification of wandering as "normal" but he/she had risk factors including ambulatory status, dementia, and a history of wandering.</p> <p>Observation on 8/9/16 at 9:37 A.M. revealed the resident lay in bed sleeping with the bed in a low position and the call light within reach. A WanderGuard was not visible on the resident.</p> <p>Observation on 8/10/16 at 4:45 P.M. revealed the resident stood independently from the dining room chair and ambulated with his/her walker to</p>	F 278			

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F 278	<p>Continued From page 3</p> <p>use the telephone on the counter. A WanderGuard was not visible on the resident.</p> <p>During an interview on 8/10/16 at 4:45 P.M., resident #33 stated she is able to walk around the unit independently but does not wear a WanderGuard.</p> <p>During an interview on 8/10/16 at 2:40 P.M., direct care staff O stated each unit had an elopement book which indicated residents who were at risk of wandering and had a WanderGuard on. Direct care staff O stated the resident was not considered an elopement risk, had never wandered off of the unit, and did not wear a WanderGuard.</p> <p>During an interview on 8/10/16 at 2:46 P.M., licensed nursing staff H stated the resident was not at risk for elopement and had never displayed wandering behaviors.</p> <p>During an interview on 8/10/16 at 4:53 P.M., licensed nursing staff K stated the resident has never worn a WanderGuard and has never exhibited wandering or elopement behavior.</p> <p>During an interview on 8/11/16 at 6:45 A.M., direct care staff P stated the resident does not wear a WanderGuard and has never tried to exit the unit or facility.</p> <p>During an interview on 8/11/16 at 4:30 P.M., administrative nursing staff E stated the comprehensive assessment dated 5/13/16 was completed by a previous employee and because the wandering classification of this resident was "normal," he/she should not be considered an elopement risk.</p>	F 278			

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F 278	<p>Continued From page 4</p> <p>During an interview on 8/11/16 at 5:19 P.M., administrative nursing staff D stated the resident was assessed on admission and was determined not to be at risk for elopement and confirmed the MDS dated 5/13/16 was inaccurate.</p> <p>During an interview on 8/11/16 at 5:30 P.M., administrative nursing staff D stated he/she expected the MDS nurse to review the resident's ADL reports, interview the staff and make observations to ensure the information recorded on each resident was accurate.</p> <p>The facility provided MDS Data Accuracy Policy dated February 2016 lacked documentation regarding prevention of MDS errors and ensuring accuracy of entered clinical data.</p> <p>The facility failed to complete an accurate comprehensive assessment and identified the resident to be at risk of wandering that was not actually an elopement risk.</p> <p>- Review of resident #6's signed physician order sheet dated 7/29/16 documented diagnoses of cerebral palsy (a group of nerve disorders that appear in infancy or early childhood and permanently affect body movement, muscle coordination, and balance), speech disturbances, and muscle wasting.</p> <p>Review of the Significant Change Minimum Data Set (MDS) dated 3/25/16 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident required extensive assistance from staff with all activities of daily living (ADLs), did not walk, and required supervision of one staff with locomotion on and off the unit. The resident received hospice</p>	F 278			

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F 278	<p>Continued From page 5 services.</p> <p>Review of the Quarterly MDS dated 6/25/16 documented a BIMS score of 15, which indicated intact cognition. The resident required extensive assistance from staff with all ADLs, did not walk, and required total dependence of one or more staff with locomotion on and off the unit. The MDS lacked documentation of hospice services for the resident.</p> <p>Review of the ADL Care Area Assessment (CAA) dated 3/25/16 documented the resident was on hospice services for end stage cerebral palsy and dysphagia (difficulty or discomfort in swallowing).</p> <p>Review of the resident's care plan dated 7/1/16 documented the resident was on hospice for end stage cerebral palsy with dysphagia.</p> <p>Review of the physician orders from March 2016 documented an order for hospice services with a diagnosis of dysphagia related to end stage cerebral palsy.</p> <p>During an observation on 8/09/2016 at 4:20 P.M. the resident sat at a table in his/her wheelchair. He/she spoke slowly, was calm, and friendly. He/she was well groomed and appropriately dressed.</p> <p>During an interview on 8/11/2016 at 12:19 P.M. administrative nursing staff E confirmed that the quarterly MDS dated 6/25/16 did not document that the resident was on hospice. He/she stated that it was missed.</p> <p>During an interview on 8/11/2016 at 5:30 P.M. administrative nursing staff D stated the MDS</p>	F 278			

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F 278	Continued From page 6 nurse would review the resident's ADL reports, interview the nurses, direct care staff and therapy staff, and also made several observations of residents to ensure what was recorded on the MDS was accurate.  The facility provided "MDS Data Accuracy Policy" dated February 2016 lacked documentation regarding prevention of MDS errors and ensuring accuracy of entered clinical data.	F 278			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 17 residents. Based upon observation, record review and interviews the facility failed to develop and implement timely and effective interventions to prevent a pressure ulcer for 1 (#72) of 3 residents reviewed for pressure ulcers, who developed an unstageable pressure ulcer.	F 314			

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F 314	Continued From page 7  Findings included:  - Review of the admission Minimum Data Set (MDS) dated 12/25/15 identified resident #72 had a Brief Interview for Mental Status (BIMS) of 9 (which indicated a moderately impaired cognition) required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene and required setup help only with eating. The MDS noted no pressure ulcers, however the resident was at risk for pressure ulcers.  Review of the quarterly MDS dated 06/24/16 identified the resident had a BIMS of 9 and required extensive assistance with bed mobility, transfers, dressing, locomotion on and off the unit, eating, toilet use, and personal hygiene. The MDS recorded the resident weighed 116 pounds, had experienced a weight loss of 5 percent (%) in 1 month or 10% in 6 months, was not on a physician regimen weight loss program and received a regular diet. The MDS recorded the resident had a pressure ulcer identified as a Stage 2 (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) dated 06/21/16.  Review of resident #72's significant change MDS dated 07/08/16 identified the resident had a BIMS of 6 (which indicated severely impaired cognition). The resident required extensive assistance for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. The resident was totally dependent on staff for locomotion on and off the unit. The MDS noted an unstageable pressure ulcer, measuring 1.5 centimeter (cm) x	F 314			

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F 314	<p>Continued From page 8</p> <p>0.5 cm with slough (dead tissue separating from living tissue) on the coccyx (small triangular bone at the base of the spine).</p> <p>The resident's care area assessment (CAA) dated 12/25/15 documented cognitive loss/dementia triggered due to diagnosis of dementia, and decreased appetite. The resident received medications to manage his/her depression and increase appetite.</p> <p>The resident's pressure ulcer CAA dated 12/25/15 triggered due to the resident's post surgery, poor appetite and he/she received supplements for increased calories and protein.</p> <p>The CAA for the significant change dated 07/08/16 revealed pressure ulcer triggered due to a pressure ulcer of the coccyx that was unstageable due to slough (necrotic tissue separated from the living structure) in the base of the wound. Staff cleansed the area with Saf Clens and covered with Aquacel AG (wound dressing) daily and as needed. The resident recently admitted to hospice for protein-calorie malnutrition as evidenced by weight loss which contributed to the development of wounds. The resident had a decline in function and required extensive assistance for activities of daily living (ADL) tasks. He/she spent most of his/her time sleeping in bed or the recliner. Hospice provided a low air loss mattress and gel cushion for his/her wheelchair to reduce pressure. The staff assisted with turning and repositioning but he/she could be agitated at times and may not cooperate.</p> <p>The resident's admission care plan dated 12/21/15 recorded the resident required 1 to 2</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>staff assistance for toileting and transfers; and 1 person assist for bathing.</p> <p>The physician order sheet on 06/30/16 documented the resident admitted to Hospice services with a diagnosis of protein-calorie malnutrition. Hospice provided a low air loss mattress and gel cushion for wheelchair to reduce pressure.</p> <p>The care plan dated 12/31/15 had the resident at risk for pressure ulcer with interventions of a pressure reducing mattress and assist of 1 to 2 persons with transfers. The care plan did not address repositioning.</p> <p>The care plan for pressure ulcers dated 07/19/16 recorded the resident had an unstageable wound to the coccyx. Interventions included: low air loss mattress; reposition every 2 hours in bed and hourly in wheelchair or recliner and as needed; gel cushion in wheelchair and saddle cushion in recliner; administer pain medications to reduce pain during treatment/dressing changes/evaluations.</p> <p>Evaluation of needs/recommendations/interventions for nutrition care dated 06/20/16 documented the resident's skin was intact.</p> <p>The nutrition note dated 06/29/16 noted the resident had a new stage 2 pressure ulcer to his/her coccyx. The resident started on protein shakes 120 milliliters (mL) daily.</p> <p>The nutrition note dated 07/15/16 documented the resident had a stage 2 pressure ulcer to coccyx.</p>	F 314			

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F 314	Continued From page 10  Review of the resident's Medication Administration Record revealed the resident received Carnation Instant Breakfast (CIB) 120mL twice daily from 02/02/16 through 04/18/16.  Further review revealed the facility did not record the percentage of supplement the resident consumed.  Review of the resident's monthly weight report revealed the following weights:  12/28/15: 146 pounds  01/04/16: 145 pounds  01/11/16: 143 pounds  01/18/16: 139 pounds  01/25/16: 134 pounds  From 02/02/16 through 04/18/16 the resident had physician orders to receive CIB shakes twice daily.  02/11/16: 134 pounds  03/07/16: 131 pounds  04/04/16: 126 pounds  05/02/16: 121 pounds  06/06/16: 116 pounds  On 06/29/16 the physician ordered protein shake	F 314		

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F 314	<p>Continued From page 11 120 mL to be given daily.</p> <p>07/04/16: 113 pounds</p> <p>08/01/16: 114 pounds</p> <p>The certified nurse aide (CNA) Skin Screening Detail from 03/01/16 through 06/20/16 documented the resident had no skin issues.</p> <p>On 06/21/16 on the CNA skin screening detail sheet the resident had a suspected pressure ulcer on the buttocks which staff reported to a licensed nurse.</p> <p>The physician order on 06/27/16 directed staff to measure and document wound weekly until healed.</p> <p>The physician order on 07/08/16 directed staff to cleanse the coccyx wound with Saf Clens, cover with Aquacel AG foam dressing, change every 3 days and as needed (PRN) until healed.</p> <p>On 6/21/16 the (initial) Wound report recorded: coccyx wound measured 1.5 cm x 0.5 cm; serosanguinous drainage [containing or relating to both blood and the liquid part of blood (serum)]; and slough. Interventions put in place included: Turn schedule - every 2 hours; use chair/seat cushion; pressure-reducing/relieving devices; and administer a multivitamin with minerals daily.</p> <p>On 7/4/16 the Wound report recorded: coccyx wound 1.2 cm x 0.5 cm; low drainage; slough. Cleanse wound, cover with Aquacel AG, change daily &amp; PRN. Interventions: Continue care plan.</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>On 7/11/16 the Wound report recorded: coccyx wound 0.9 cm x 0.6 cm; low drainage; slough. Cleanse wound, pat dry and cover with Aquacel AG every 3 days and PRN. Interventions: Continue care plan.</p> <p>On 7/18/16 the Wound report recorded: coccyx wound 1.0 cm x 0.5 cm; no drainage; slough. Interventions: Continue current treatment.</p> <p>On 7/25/16 the Wound report recorded: coccyx wound 0.8 cm x 0.5 cm; low drainage; slough, epithelial (sheet of cells that covers a body surface or lines a body cavity). Interventions: Continue current treatment.</p> <p>On 8/1/16 the Wound report recorded: coccyx wound 0.8 cm x 0.3 cm; low drainage; granulation (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during healing process), slough; pain assessed and medicated as indicated Interventions: Continue current treatment.</p> <p>On 8/8/16 the Wound report recorded: coccyx wound 0.5 cm x 0.3 cm; low drainage; granulation, slough; pain assessed and medicated as indicated Interventions: continue with current treatment.</p> <p>Observation on 08/10/16 revealed the following: At 1:54 PM, the resident sat in a recliner, sleeping in the living room, slightly leaning to the right side slightly, with his/her eyes closed. The resident was able to move some in the chair on his/her own, with his/her legs bent at the knee and his/her feet rested on the recliner footrest. The resident moved only slightly, not enough be</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>considered repositioned.</p> <p>At 2:10 PM, the resident sat in a recliner, both feet resting on the footrest with legs bent at the knees. Resident was sleeping, leaning to the right side.</p> <p>At 2:21 PM, Staff O came up to resident asleep in the recliner, right leg was resting on the arm of the recliner; straightened the resident's legs and covered the resident with a fleece blanket.</p> <p>At 2:35 PM, the resident sat in a recliner and had his/her right leg bent at the knee, and foot resting on the footrest, sleeping.</p> <p>At 2:50 PM, the resident slept in the recliner has right leg bent at the knee with foot flat on the leg rest and the left leg bent with left foot resting on the right foot, leaning on left hip, and sleeping.</p> <p>At 3:05 PM, the resident was in a recliner, sleeping. The resident's right leg was bent at the knee, foot flat on the footrest. Left leg slightly bent at the knee and with outside of left foot resting on the footrest.</p> <p>At 3:20 PM, the resident slept in the recliner. The resident's right leg bent at the knee, left leg slightly bent.</p> <p>At 3:35 PM, the resident was asleep in the recliner. The resident's right leg bent at the knee with foot flat on the footrest. Left leg bent at the knee and turned out to the left (hip open).</p> <p>At 3:50 PM, the resident was sleeping in the recliner with both knees bent, legs leaning to the left side, sleeping.</p> <p>At 4:05 PM, the resident was in a recliner with both knees bent, legs leaning to the left side, and was sleeping.</p> <p>At 4:10 PM, Surveyor requested a skin check for the resident who remained in the same position in the recliner.</p> <p>08/10/2016 4:12 PM Both CNAs, direct care staff</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>V and another CNA transferred the resident up into his/her wheelchair using a gait belt and took the resident to bathroom in his/her room. Direct care staff V removed the resident's dry brief and assisted the resident to the toilet. Observation revealed the resident did not have a dressing in place to the coccyx wound; which was visualized with yellow slough in the base. The resident did not urinate, and staff transferred the resident back into the wheelchair. The resident continued to lean to the left side.</p> <p>On 08/11/2016 at 11:04 AM licensed staff H and direct care staff R entered the resident's room and removed the resident's brief. A dressing dated 8/10/16 was in place. Staff removed the dressing and revealed a pencil eraser sized wound with small amount of yellow slough in the center. Licensed staff H used Saf Clens and 4x4 gauze to clean the wound and applied skin prep wipe to the area around the wound. Staff H applied the Aquacel pad to the wound area, ensured a good seal all the way around on skin.</p> <p>During an interview on 08/10/2016 at 4:27 PM direct care staff V stated staff took the resident to the restroom before dinner in the evening, after dinner and around 8:00 PM. The resident went to bed around 10:30 PM before evening shift left, so staff took him/her to the bathroom again. Probably twice during those checks the resident would have already urinated. Each time we check him/her, we also reposition the resident to try to keep the weight off him/her bottom.</p> <p>During an interview on 08/11/2016 at 9:53 AM Direct care staff T stated the family requested to let the resident sleep as long as he/she would like. If he/she wake up before lunchtime then staff</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>would order whatever he/she would like from the kitchen or staff could make him/her toast since we keep bread on the unit. He/she does better with finger foods rather than utensils and staff have to feed him/her often. CNAs do not record a percentage of food eaten. Most of the time the nurse attempted to get the resident to drink the Boost, but he/she refused that a lot of times. On a good day, the resident normally ate 50% of his/her food with assistance/cues. If staff doesn't assist the resident then he/she probably only eats 15% and a lot of food ends up in his/her lap.</p> <p>During an interview on 08/10/2016 at 4:31 PM licensed staff K referred to the Treatment Administration Record (TAR) book and stated the physician order directed the resident's coccyx wound to have Aquacel AG foam changed every 3 days and PRN. Direct care staff should reposition and provide incontinence care every hour or two hours when in the recliner and try to ensure that they shift weight from one side to the other to offsite at each position change.</p> <p>During an interview on 08/09/16 at approximately 2:00 PM licensed staff H stated either he/she changed the dressing as ordered or there was a wound nurse could also perform dressing changes.</p> <p>During an interview on 08/11/2016 at 10:16 AM licensed staff H stated the resident's pressure ulcer occurred after his/her mobility declined and he/she stopped walking. Staff obtained wound measurements weekly. The most current order directed staff to change the dressing every 3 days, but due to the area involved, staff usually changed the dressing daily. Nurses do not measure the wound at each dressing change.</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>The wound nurse measured the wound during the assessment. The resident doesn't like sweet flavors, and he/she refuses the Boost shake. The resident likes coffee and sometimes juice.</p> <p>During an interview with Administrative staff D on 08/11/2016 at 1:07 PM he/she stated the facility had a weekly risk meeting, and each neighborhood nurse identified their residents weight losses and brought them to the meeting. The Certified Dietary Manager (CDM) also ran a report for weight loss and brought it to the meeting. Any resident who had a weight loss or risk of weight loss - interventions were collaborative and individual to the residents. The resident began receiving CIB shakes in January twice daily (BID). There was a product change in April to fortified shakes BID, which were discontinued on June 20th. Boost between meals three times daily (TID) ordered 06/23/16. Hospice and the family asked us to not do anything that the resident did not want us to do when the resident hit the 5% weight loss mark from the previous months. We compare monthly weight up to 6 months prior. In March the resident was under the cutoff for requiring weekly weights. However, by April since the resident was at 9.75% weight loss from admission then he/she should have been initiated for weekly weights. Staff recorded meal intake percentage by exception. The system flagged if residents ate less than 75% of meals in the previous 24 hours. The facility did not complete any meal tracking for the resident in the last 6 months. The risk meeting involved the neighborhood staff who worked with the resident every day. The staff on the floor began assisting the resident to eat starting in May, and dietary staff provided more finger foods because</p>	F 314			

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F 314	<p>Continued From page 17 at times he/she did not want staff assistance.</p> <p>During an interview with Consultant dietary staff II on 08/15/16 at 10:30 A.M. he/she stated that he/she began consulting in June. He/she was at the facility once a month, sometimes more if a resident needed to be seen immediately such as in cases of weight loss, or a hospice admission. The dietary manager gave a printed report of new residents; use this list to review in the facility to look for weight loss, new pressure ulcers, new to hospice care and annual reviews. He/she also got a copy of Risk meetings of possible concerns. In regards to a significant weight loss, his/her standard would be to speak to the resident, ask if he/she had trouble chewing or swallowing, and if he/she liked the foods being served. If the resident was unable to speak, then I would speak to the family or nurse to find out what types of food the resident enjoys or if the resident was having any trouble eating. He/she also review the need for assistance at meals. Interventions were recommended based on the interview process for what would work best for that particular resident. He/she review weights to ensure that there was a true trend versus triggering for a fluctuation in weight.</p> <p>During an interview with consultant medical staff KK on 08/15/16 at 10:00 A.M., staff KK stated he/she was at the facility three times a week and that nursing staff usually reported to him/her while at the facility and he/she was also available by fax to receive resident updates. The resident was usually seen by another provider. If a resident is refusing supplements, then I would expect to be notified. However, I wouldn't expect a percentage of supplement intake to be recorded.</p>	F 314			

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F 314	Continued From page 18  During an interview with consultant medical staff JJ on 08/15/16 at 10:05 A.M., staff JJ stated if significant weight loss occurred it would have triggered the dietician to see him/her. The resident was difficult to treat due to his/her dementia and refusing medications. His/her general resistance to cares made it difficult to prevent weight loss. In regards to weight loss causing a pressure ulcer, it was a component but his/her resistance to cares was more likely the culprit.  Review of Skin integrity policy dated July 2013 revealed that nursing staff would assess skin integrity, implement preventative measures as indicated and treat skin breakdown. The primary care provider (PCP) admission orders authorize approval to begin using established skin and wound treatment guidelines. Dressing changes were performed by a licensed nurse. Nurses may delegate minor skin treatments and preventative treatments on closed areas to certified medication aides (CMA) who have received the appropriate skin care training.  The facility failed to develop and implement timely and effective interventions for this cognitively impaired dependent resident to prevent the development of an unstageable pressure ulcer.	F 314			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325			

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F 325	<p>Continued From page 19 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 17 residents. Based upon observation, record review and interviews the facility failed to develop and implement timely interventions to prevent weight loss for 1 (#72) of 4 residents sampled for nutrition. Resident #72 lost 16.55% of his/her weight in a 6 month period.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of resident #72's admission Minimum Data Set (MDS) dated 12/25/15 identified the resident had a Brief Interview for Mental Status (BIMS) score of 9 and required setup help only with eating. The MDS noted that the resident required no special nutritional approaches and had no chewing or swallowing problems. The MDS recorded the resident weighed 141 pounds with no weight loss or weight gain.</li> </ul> <p>Review of the resident's quarterly MDS dated 06/24/16 identified the resident had a BIMS of 9 and required extensive assistance with eating. The MDS noted the resident required no special nutritional approaches and no chewing or swallowing problems. The MDS recorded the resident weighed 116 pounds, had experienced a weight loss of 5 percent (%) in 1 month or 10% in 6 months, was not on a physician ordered</p>	F 325		

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F 325	<p>Continued From page 20</p> <p>regimen weight loss program, and received a regular diet to be adjusted on level of alertness.</p> <p>The resident's care area assessment (CAA) dated 12/25/15 revealed nutrition did not trigger.</p> <p>The CAA dated 12/25/15 revealed cognitive loss/dementia triggered due to diagnosis of dementia, and stated resident had decreased appetite and received medications to manage his/her depression and increase appetite.</p> <p>The CAA dated 12/25/15 revealed pressure ulcer triggered due to resident was status post surgery, had poor appetite and received supplements to increase calories and protein.</p> <p>The resident's admission care plan documented the resident was at risk for alterations in nutrition related to recent hip fracture, history of dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and short term memory impairment. An entry dated 12/23/15 revealed the resident preferred a regular diet and could make his/her needs known and that sometimes he/she forgot he/she had already eaten. Staff weighed the resident weekly while on Med A services (post acute care rehabilitation).</p> <p>The 12/23/16 care plan documented the resident was to be offered CIB shakes twice daily between meals. On 01/28/16 it was documented on the care plan for the resident to have a regular diet adjusted by level of alertness.</p> <p>Staff revised the care plan revised 03/28/16</p>	F 325			

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F 325	<p>Continued From page 21</p> <p>revealed the resident preferred a regular diet and could make his/her needs known. Staff provided assistance with meal setup as needed and were to weigh monthly. Staff updated the care plan on 04/18/16 to change CIB shake order to fortified milk shake 120 milliliter (mL) by mouth twice daily between meals for weight loss. On 06/20/16 CIB shakes/fortified shakes were discontinued; the physician ordered Boost 90 mL supplement three times a day in replacement and added fortified foods at meals.</p> <p>The nutritional progress note dated 02/01/16 revealed the resident had an 8.08% weight loss change in 30 days per weight report and noted insidious (denoting a disease that progresses gradually with inapparent symptoms) weight loss in 180 days. The resident received a regular diet with fair intake. A functional decline note - discussed with nursing that the resident had increased lethargy/drowsiness and needed cueing at meals. He/she received CIB shake twice daily which he/she accepted well per nursing. The clinical record lacked evidence of additional interventions to prevent weight loss.</p> <p>The risk meeting note for the week of 04/28/16 through 05/04/16 documented that staff discussed the resident's weight loss. Interventions put in place included a fortified shake twice daily, staff offered and provided snacks, speech evaluation and treatment, offer more sweet items and the family provided ginger snap cookies.</p> <p>The evaluation of needs/recommendations/interventions for nutrition care dated 06/20/16 revealed the resident's weight on 06/06/16 was 115.5 pounds,</p>	F 325			

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F 325	<p>Continued From page 22</p> <p>a 4.3% loss in 30 days, 11.6% loss in 90 days, 17.9% loss in 180 days. The resident received a regular diet, and fortified shakes twice daily. The resident's intake varied per nursing. The resident was lethargic, became agitated when awakened to eat and ate very little. Staff recommended to discontinue shakes and try Boost 90 mL three times daily. Staff may need to consider alternate nutrition if appropriate.</p> <p>The nutrition note dated 06/29/16 noted the staff started the resident on a protein shake 120mL daily.</p> <p>The dietary screening for significant change dated 07/08/16 revealed the resident's weight was 112.8 pounds which indicated a 22% decline in 180 days. The resident received a regular diet with thin liquids, and supplement Boost three times daily. The staff reported/observed meal consumption as less than 75% on all meals and the resident's dental status was adequate. Staff were to offer snacks between meals.</p> <p>Review of the resident's Medication Administration Record revealed the resident received CIB 120mL twice daily starting 02/02/16 through 04/18/16 per the physician order. The clinical record lacked evidence the resident received CIB from 12/23/15 through 02/02/16 as planned.</p> <p>Further record review revealed the facility did not record the percentage of supplement the resident consumed.</p> <p>Review of the resident's monthly weight report revealed the following weights:</p>	F 325			

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F 325	Continued From page 23 12/19/15: 139 pounds at time of admission.  12/28/15: 146 pounds  01/04/16: 145 pounds  01/11/16: 143 pounds  01/18/16: 139 pounds  01/25/16: 134 pounds  Upon review of the medication administration record the resident received CIB as planned starting 02/02/16.  02/11/16: 134 pounds  03/07/16: 131 pounds  04/04/16: 126 pounds  On 04/18/16 physician ordered CIB shakes changed to fortified milk shake.  05/02/16: 121 pounds  06/06/16: 116 pounds  On 06/20/16 physician ordered to discontinue CIB and fortified milk shake and replace with fortified foods and Boost three times daily.  On 06/29/16 physician ordered protein shake 120 mL daily.  07/04/16: 113 pounds  08/01/16: 114 pounds	F 325			

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F 325	<p>Continued From page 24</p> <p>The record lacked evidence the resident was reassessed for continued weight loss.</p> <p>Labs reviewed from admission. The resident was assessed for albumin levels on 4 occasions and prealbumin once. On 01/19/16 albumin level was 3.5, the normal level is 3.5 to 5.7. On 03/19/16 albumin level was 3.6. On 06/20/16 albumin level was 3.7. On 06/29/16 albumin level was 3.3. On 06/29/16 prealbumin level was 16, the normal value is 17 to 34.</p> <p>On 08/11/16 the resident stayed in bed until approximately 11:20 A.M., when direct care staff R transferred the resident to the wheelchair and wheeled the resident into the living room area where an activity was going on. The staff did not give or offer the resident anything to eat.</p> <p>On 08/11/2016 at 1:22 PM direct care staff Q stated the resident ate teriyaki chicken and rice, green beans, and lentil soup and stated the resident ate 100%. The resident sat in his/her high back wheelchair and stated lunch was "bleh." Staff Q assisted the resident to eat a small bowl of ice cream. The resident ate 50% of the ice cream.</p> <p>During an interview on 08/11/16 at 9:53 A.M., direct care staff T stated the resident's family requested to let the resident sleep as long as he/she would like to. If he/she woke up before lunchtime then staff ordered whatever he/she would like from the kitchen or staff could make him/her toast. Staff had to feed the resident a lot of times. The certified nurse aides (CNA) did not</p>	F 325			

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F 325	<p>Continued From page 25</p> <p>record a percentage of food eaten. Most of the time the nurse attempted to get the resident to drink the Boost, but the resident often refused. On a good day, the resident ate approximately 50% of his/her food with assistance and cues. If he /she did not get assist, then he/she only ate approximately 15% and a lot of food ended up in his/her lap. Staff obtain weights on the first Monday of every month, reported to the nurse and the nurse compared the weight to the month before.</p> <p>During an interview on 08/11/16 at 10:16 A.M., Licensed staff H stated that the resident did not like sweet flavors, so he/she refused the Boost shake. If he/she refused, staff tried different foods. Staff H offered Magic Cup a dietary supplement, a couple of times. Weights are obtained once a month. CNAs weighed the residents and they reported to the nurse. The nurses entered the weights in to the computer, and it sent an alert to the Dietician and the assistant director of nursing (ADON). The dietician came down that day to assess a weight loss and any recommendations would be started instantly. Weight issues would be addressed weekly at the Risk meeting. If there was a problem, the dietician reviewed the information then the physician or nurse practitioner would put in new orders if necessary.</p> <p>During an interview with Administrative staff D on 08/11/2016 at 1:07 PM he/she stated the facility had a weekly risk meeting, each neighborhood nurse identified their residents weight losses and brought them to the meeting. The Certified Dietary Manager (CDM) also ran a report for weight loss and brought it to the meeting. Any resident who had a weight loss or risk of weight</p>	F 325			

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F 325	<p>Continued From page 26</p> <p>loss interventions were collaborative and individual to the residents. The resident began receiving CIB shakes in January twice daily (BID). There was a product change in April for fortified shakes BID. Fortified shakes were discontinued on June 20th and implemented Boost between meals three times daily (TID). Hospice and the family asked us to not do anything that the resident did not want us to do when the resident hit the 5% weight loss mark from the previous months. We compare monthly weight up to 6 months prior. In March the resident was under the cutoff for requiring weekly weights, however by April since the resident was at 9.75% weight loss from admission then he/she should have been initiated for weekly weights. Staff recorded meal intake percentage is done on exception, the system flagged if they were eating less than 75% of meals in the previous 24 hours. The facility did not complete any meal tracking for the resident in the last 6 months. Staff involved the neighborhood staff in the risk meetings, they work with the resident every day. The staff on the floor began assisting the resident to eat starting in May, and dietary provided more finger foods because at times he/she did not want staff assistance.</p> <p>During an interview on 08/15/16 at 10:30 A.M. consultant dietary staff II stated that he/she was at the facility once a month, sometimes more if a resident needed to be seen immediately such as in cases of weight loss, or being placed on hospice. The dietary manager gave him/her a printed report of new residents. He/she used the list to review in the facility to look for weight loss, new pressure ulcers, new to hospice care and annual reviews. Consultant staff II also received a copy of Risk meetings of possible concerns. In</p>	F 325			

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F 325	<p>Continued From page 27</p> <p>regards to a significant weight loss, his/her standard would be to speak to the resident, ask if he/she was having trouble chewing or swallowing, and if he/she liked the foods being served. If the resident was unable to speak, then consultant staff II spoke to the family or nurse to find out what types of food the resident enjoyed or if they are having any trouble eating, and also reviewed the need for assistance at meals. He/she would then recommend interventions based on the interview process for what would work best for that particular resident.</p> <p>During an interview on 08/15/16 at 10:00 A.M., consultant medical staff KK stated he/she was at the facility three times a week and nursing staff usually caught him/her while at the facility and he/she was available by fax to receive resident updates. The resident was usually seen by another provider. If a resident refused supplements, then he/she would expect staff to notify him/her.</p> <p>During an interview on 08/15/16 at 10:05 A.M., consultant medical staff JJ stated he/she was on leave from March through June. If significant weight loss occurred it would have triggered the dietician to see the resident. The resident was difficult to treat due to his/her dementia and he/she refused medications. His/her general resistance to cares made it difficult to prevent weight loss.</p> <p>The nutritional status policy dated February 2008 stated that a comprehensive assessment by the facility would ensure that the resident maintained acceptable parameters of nutritional status such as body weight and protein levels, unless the resident's clinical condition demonstrated this</p>	F 325			

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F 325	Continued From page 28 was not possible.	F 325			
F 371 SS=F	<p>The facility failed to develop and implement timely and effective interventions for this cognitively impaired, dependent resident who experienced a significant weight loss.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 46 residents served from 1 of 1 kitchen and 4 of 4 neighborhood kitchenette/dining areas. Base on observation, staff interview, and record review, the facility failed to store dishes, serving utensils, food, and maintain proper water temperatures in the automatic dishwasher in 1 of 1 kitchens. The facility also failed to serve food from 2 of 4 neighborhood kitchenette/dining areas to residents, in a sanitary manner.</p> <p>Findings include:</p> <p>- Observation in the main kitchen on 8/8/16 at 8:25 A.M. revealed 11 of 34 round cake pans stored right side up on a storage shelving unit</p>	F 371			

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F 371	<p>Continued From page 29 against the wall closest to the kitchen entrance.</p> <p>Observation on 8/8/16 at 8:28 A.M. revealed clean plates and bowls stored right side up on a serving cart. Dishes on top of the cart were covered with cloth napkins.</p> <p>Observation on 8/8/16 at 9:05 A.M. revealed 9 clean muffin pans stored upright on shelving storage unit.</p> <p>Observation on 8/8/16 at 9:25 A.M. revealed bowls, plates, and serving items stored upright in an open storage area.</p> <p>Interview on 8/8/16 at 9:25 A.M. dietary staff member DD confirmed it is the facility's policy to have all kitchen items that food are cooked in or served on turned upside down.</p> <p>The facility failed to provide a policy on dinnerware storage.</p> <p>The facility failed to follow sanitary storage procedures for dinnerware and serving utensils.</p> <p>- Observation in the main kitchen on 8/8/16 at 8:38 A.M. on the second shelf of the main refrigerator approximately 3 to 4 stalks of asparagus left open to air on a pan and undated.</p> <p>Observation on 8/8/16 at 9:01 A.M. behind the "leftover" refrigerator 1 whole onion found on the floor against the wall.</p> <p>Observation on 8/8/16 at 9:08 A.M. on a shelf in the main refrigerator approximately 4-5 stalks of green onions left open to air on a pan and undated.</p>	F 371			

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F 371	<p>Continued From page 30</p> <p>Observation on 8/8/16 at 9:13 A.M. on a top shelf of the walk in freezer an opened Moores brand box containing onion rings was undated and unsealed.</p> <p>Observation on 8/8/16 at 9:22 A.M. in the dry pantry area approximately 7-8 dry beans were open to air on a pan.</p> <p>Interview on 8/8/16 at 9:08 A. M. dietary staff member EE confirmed that loose food items in the refrigerator should be contained and labeled.</p> <p>Interview on 8/8/16 at 9:22 A.M. dietary staff member DD confirmed that loose food item in the dry pantry should be removed and discarded.</p> <p>Facility failed to provide a policy on food storage.</p> <p>The facility failed to store food under sanitary conditions</p> <p>- Observation on 8/10/16 in neighborhood kitchenette/dining area A between 11:52 A.M. and 12:28 P.M. dietary staff member FF with gloved hand touched bread and turkey. With his/her same gloved hand opened locked security door from the steam table area then touched the refrigerator in the kitchenette area and made a sandwich. Staff member FF continued to touch rolls and menu order sheets with same gloved hands. He/she did not change gloves between tasks.</p> <p>Interview on 8/10/16 at 12:28 P.M. dietary staff member FF stated he/she changes his/her gloves when going in and out of the kitchen area or when the gloves are wet.</p>	F 371			

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F 371	<p>Continued From page 31</p> <p>Interview on 8/10/16 at 3:54 P.M. dietary staff member DD stated staff changed gloves whenever leaving the kitchenette area, and hands should be washed with clean gloves donned or use paper towel or tongs when handling food directly. Staff changed gloves when working with a different resident.</p> <p>Observation on 8/8/16 in neighborhood kitchenette/dining area B between 12:09 P.M. and 12:36 P.M. direct care staff T placed hair net upon head without completely covering his/her pony tail. He/she donned gloves, opened the steam table, then touched the back of his/her scrub top two times. He/she then removed the lids from the steam table to obtain food temperatures then recorded the temperatures in the log book. With the same gloved hands he/she then retrieved bowls from the upper cabinet by touching the inside of the bowls prior to filling with soup. He/she continued to reach for more bowls, touching the inside of each bowl with the same gloved hand. He/she touched his/her scrub top, served coffee, then touched the food contact area of a divided plated before pureed food was served to a resident. Without changing gloves, direct care staff F removed salad bowl from the refrigerator then removed disposable cups from a drawer. Direct staff F then put full thumb on the rim of the plate and served it to a resident. The same staff member took another plate from the cupboard touching the food contact area with same unchanged gloved hand, touched his/her scrub top and took another plate from the cupboard.</p> <p>Interview on 8/8/16 at 1:00 P.M. direct care staff T stated all of his/her hair should have been</p>	F 371			

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F 371	<p>Continued From page 32</p> <p>covered and he/she did not realize he/she was touching his/her scrub top with gloved hands and then plated food that was served to residents.</p> <p>Interview on 8/11/16 at 11:54 A.M. dietary staff member DD stated staff wore hair nets any time a staff member was in the main kitchen or when behind the secured area in the neighborhood kitchenettes; all hair should be covered including ponytails.</p> <p>The facility failed to provide policy on food serving policy and hairnet policy.</p> <p>The facility failed to follow sanitary procedures when serving food to residents in 2 of 4 neighborhood kitchenette/dining areas.</p> <p>- Observation on 8/9/16 10:50 A.M. of the automatic dishwasher revealed the wash cycle temperature reached 174 degrees F and the final rinse cycle temperature reached 140 degrees F.</p> <p>Observation on 8/10/16 at 11:27 A.M. of the automatic dishwasher in the presence of dietary staff member DD, the wash cycle temperature reached 168 degrees F and the final rinse cycle temperature reached 174 degrees F.</p> <p>Observation on 8/10/16 at 11:28 A.M. of the automatic dishwasher in the presence of dietary staff member DD, the wash cycle temperature reached 150 degrees F and the final rinse cycle temperature reached 176 degrees F.</p> <p>Observation on 8/10/16 at 12:19 P.M. of the automatic dishwasher in the presence of dietary</p>	F 371			

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F 371	<p>Continued From page 33</p> <p>staff member DD and maintenance staff member Z, the wash cycle temperature reached 140 degrees F and the final rinse cycle temperature reached 185 degrees F.</p> <p>Observation on 8/11/16 at 12:12 P.M. of the automatic dishwasher, the wash cycle temperature reached 134 degrees F and the final rinse cycle temperature reached 164 degrees F.</p> <p>Observation on 8/11/16 at 12:14 P.M. of the automatic dishwasher in the presence of dietary staff member DD, the wash cycle temperature reached 134 degrees and the final rinse cycle temperature reached 178 degrees.</p> <p>Interview on 8/10/16 at 11:28 A.M. dietary staff member DD confirmed the final rinse temperatures did not reach the required minimum temperature of 180 degrees Fahrenheit.</p> <p>Interview on 8/10/16 at 12:21 P.M. maintenance staff member Z confirmed the present dishwashing machine was installed as a new unit 4 years ago and that the wash temperature gauge and rinse temperature gauges were installed opposite of how they should have been installed and the correct gauge to read for the final rinse temperature was in a location towards the back of the machine. He/she confirmed the wash cycle temperature did not reach the required minimum of 150 degrees and that it may not be reaching 150 degrees consistently.</p> <p>Interview on 8/10/16 at 12:21 P.M. dietary staff member DD confirmed the wash cycle temperature did not reach the required minimum of 150 degrees and agreed with maintenance staff member Z that it may not be reaching 150</p>	F 371			

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F 371	Continued From page 34 degrees consistently.  Interview on 8/11/16 at 12:14 P.M. dietary staff member DD confirmed the automatic dishwasher wash cycle temperature nor the final rinse cycle temperature reached the required minimum temperatures.  Review of the Ecolab report dated 8/10/16 documented the State Health Department discovered the final rinse temperature gauge was not registering properly and that the gauges were installed opposite to the labeling displayed.  Review of the facility automatic dishwashing machine July temperature log lacked documentation on 10 days and documented below standard temperatures on two days.  Review of the facility automatic dishwashing machine August temperature lacked documentation on five days and documented below standard temperatures on one day.  Review of the facility maintenance schedule policy dated October 1, 1996 revealed the preventive maintenance schedules are developed and implemented to assure that equipment is maintained in a safe and operable manner and the maintenance director is responsible for developing and maintaining service to assure that equipment is maintained in a safe and operable manner.  The facility failed to keep essential kitchen equipment maintained in safe operating condition.	F 371			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 35</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. The sample included 17 residents. Based on</p>	F 431			

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F 431	<p>Continued From page 36</p> <p>observation, record review, and interview, the facility failed to provide a separately locked, permanently affixed compartment for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 for 1 of 4 days in 1 of 2 medication rooms.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Observation on 8/8/16 at 9:12 A.M. of the medication room on the second floor revealed an unlocked cabinet with a Narcotics eKit (an emergency supply of medications) which contained the following Schedule II medications (drugs that are considered dangerous with a high potential for abuse, with use potentially leading to severe psychological or physical dependence) Fentanyl 12 micrograms (mcg), Fentanyl 25 mcg, Fentanyl 50 mcg, Fentanyl 75 mcg, Hydrocodone 5/325 milligram (mg), Hydrocodone 7.5/325 mg, Morphine sulfate 100 mg/5 milliliter (mL), Morphine sulfate controlled release 15 mg, Morphine sulfate immediate release 15 mg, Oxycodone controlled release 10 mg, Oxycodone immediate release 5 mg, Oxycodone/APAP 5/325 mg, Diphenoxylate/Atropine 2.5 mg, and Zolpidem 5 mg.</li> </ul> <p>During an interview on 8/8/16 at 9:16 A.M., licensed nursing staff M stated the cabinet that contained the narcotic box should be locked.</p> <p>During an interview on 8/8/16 at 2:01 P.M., licensed nursing staff L stated the narcotic box should be locked in the cabinet above the counter.</p> <p>During an interview on 8/11/16 at 7:00 P.M.,</p>	F 431			

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F 431	Continued From page 37 administrative staff B stated the cabinet that contained the narcotic box should be kept locked when not in use.	F 431			
F 441 SS=F	The facility failed to store Schedule II medications in a double locked compartment. 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 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441			

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F 441	<p>Continued From page 38</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: The facility identified a census of 46 residents. Based on observation, interview, and record review the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection on 2 of 4 neighborhoods for 2 of 4 days of the survey.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- During an observation on 8/10/2016 at 6:55 A.M. licensed staff H performed a blood sugar check on a resident and wrapped the lancet and test strip in his/her glove and placed the used glove in his/her pocket. Licensed staff H exited the resident's room and placed the contents of the glove into the sharps container at the nurses' station. During an interview at that time, staff nurse H explained that the lancet and test strip would be placed in the sharps container after use.</li> </ul> <p>During an interview on 8/11/2016 at 10:26 A.M. administrative nursing staff D stated that best practice would be for the nursing staff to place the lancet and test strip directly into the sharps container. If the sharps container was not readily available, the staff were to place the lancet and test strip in a glove and carry it in their hand to the sharps container, not place the used glove in</p>	F 441			

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

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F 441	<p>Continued From page 39</p> <p>his/her pocket.</p> <p>During an observation on 8/10/2016 at 2:34 P.M. housekeeping staff X performed a room cleaning and wiped the lamp and dressers with a cloth that contained Ecolab 456 II disinfectant cleaner.</p> <p>During an observation on 8/10/2016 at 2:35 P.M. housekeeping staff X cleaned the bathroom sink with a cloth containing Ecolab disinfectant cleaner.</p> <p>During an observation on 8/10/2016 at 2:36 P.M. housekeeping staff X cleaned the outside of the toilet with a cloth that contained Ecolab disinfectant cleaner.</p> <p>During an interview on 8/10/2016 at 2:42 P.M. housekeeping staff Y stated that the disinfectant cleaner would be wiped onto a surface with a cloth and allowed to air dry. He/she was unable to state how long the cleaner needed to stay on a surface to kill germs/bacteria prior to being wiped off.</p> <p>During an interview on 8/10/2016 at 3:16 P.M. housekeeping staff Y presented a copy of the Ecolab 456 II product specification document dated 4/2011, which instructed staff to thoroughly wet surfaces with a cloth, mop, sponge, sprayer or by immersion. Treated surfaces must remain wet for 10 minutes. Staff Y confirmed that the surfaces were only wiped with a cloth that contained the Ecolab disinfectant cleaner. He/she would expect staff to keep the cleaner on the surface for 10 minutes before wiping off.</p> <p>During an observation on 8/11/2016 at 8:31 A.M. direct care staff U walked down the hall with a</p>	F 441			

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F 441	<p>Continued From page 40</p> <p>linen blanket over his/her left shoulder, touching his/her shirt.</p> <p>During an interview on 8/11/2016 at 8:55 A.M. direct care staff U stated the linen was clean and he/she was taking it to a resident's room as it was the resident's own blanket. Staff U stated the linen should be transported in a plastic bag.</p> <p>During an interview on 8/11/2016 at 10:26 A.M. administrative nursing staff D stated nursing staff would carry clean linen in a plastic bag when transported in the hall.</p> <p>The facility's "Needle/sharps Handling" policy dated 4/2011 documented that sharps/needles would be disposed of in an identified sharps disposal container at the point of use.</p> <p>The facility's "Infection Control" policies dated 10/1996 and 10/2015 lacked documentation of disinfectant cleaner use for room cleaning and transportation of linens.</p> <p>The facility failed to provide a safe and sanitary environment for residents to prevent the spread of infection.</p>	F 441			