

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

PRINTED: 05/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175277</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDON WOODS AT ALVAMAR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1501 INVERNESS DRIVE LAWRENCE, KS 66047</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 280 SS=D	<p>The following citations represent findings of a Health Resurvey and Complaint Investigations #90155, #91729, #91804, #93487, and #100137.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</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: The facility had a census of 94 residents. The sample included 18 residents. Based on observation, record review and interviews, the facility failed to revise the care plan for 3 (#86, #110 and #141) regarding falls.</p> <p>Findings included :</p>	F 280			
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 280	<p>Continued From page 1</p> <p>- The POS (physician order sheet) for resident #86, dated and signed on 03/19/2016, documented diagnoses including moderate dementia (progressive mental disorder characterized by failing memory, confusion), a history of falls, and syncope (fainting, losing consciousness).</p> <p>The Annual MDS (minimum data set), dated 07/29/2015, documented the resident had a BIMS (brief interview for mental status) score of 12, which indicated moderately impaired cognition. The resident's functional status was documented as independent with bed mobility, transfers, walking in room, dressing, and toilet use. The resident needed supervision with walking in the corridor, locomotion and personal hygiene.</p> <p>The Cognitive loss/dementia CAA (care area assessment), dated 08/03/2015, documented the resident had a diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) disease, and a BIMS score of 12, which indicated moderately impaired cogitation.</p> <p>The ADL (activities of daily living) functional/Rehabilitation potential CAA, dated 08/03/2015, documented the resident was able to perform ADLs, some with supervision due to the diagnosis of dementia and continued decline.</p> <p>The Falls CAA, dated 08/03/2015, documented the resident had long and short term memory deficits. The resident used a walker for stability, sight supervision to monitor for changes in function, and took medications which had a potential to cause falls.</p>	F 280			

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F 280	Continued From page 2  The care plan, dated 09/08/2014, and reviewed on 04/13/2016, directed the staff to help the resident keep his/her room decluttered, notify the nurse when the resident experienced changes in his/her gait or ability to transfer, keep the call light within reach, check on the resident at least every 2 hours when the resident was in his/her room, place nonskid strips in front of the closet, remind the resident not to drag his/her feet when walking, and to keep the walker close.  The care plan lacked interventions for the falls, documented in the fall investigations, on 10/04/2015, 12/15/2015, 04/29/2016 and 05/04/2016.  The fall investigation, dated 10/04/2015 at 7:15 PM, documented a witnessed fall when the resident ambulated in the hallway with his/her walker. The resident took a step forward, but the other foot didn't follow, which caused the resident to lose his/her balance and to fall to the floor, landing on the right side.  The fall investigation, dated 12/15/2015 at 2:20 PM, documented an unwitnessed noninjury fall as the resident was found in his/her room attempting to use the bed to raise him/her up off the floor.  The fall investigation, dated 04/29/2016 at 6:15 AM, documented an unwitnessed, noninjury fall. The resident was found on the floor in his/her room. The witness statement documented the resident was sat on the floor, and was undressed from the waist down. The chair cushion was on the floor next to the resident, and a wet brief laid on the floor.	F 280			

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F 280	<p>Continued From page 3</p> <p>The fall investigation, dated 05/04/2016 at 12:10 AM, documented the resident was found on the floor. The resident was unsure of what happened to cause the fall.</p> <p>Observation on 05/09/2016 at 8:12 AM revealed the resident walked down the hall independently with his/her walker, gait slow and steady.</p> <p>Observation on 05/09/2016 at 9:17 AM revealed the resident walked down the hall independently with the walker, and was reminded by the staff to pick up his/her feet and not drag them.</p> <p>Observation on 05/09/2016 at 3:45 PM revealed the resident sat in the chair in his/her room with the walker within his/her reach. The resident was wearing one boot. The resident used the walker to stand up independently, took a few steps across the room, and sat down on the bed. At 3:48 PM, the resident walked down the hall independently with the walker. He/she wore one boot on the left foot and the right foot was bare.</p> <p>On 05/10/2016 at 9:46 AM, Administrative staff D stated the residents were assessed on admission to see if they were a fall risk. The facility does not use a scored fall risk assessment, but used fall risk factors. Staff wrote a care plan based on those factors at admission and quarterly. Staff D expected nursing staff to put a new intervention in place on the resident's care plan after each fall. Staff D further stated he/she expected the nurses to start the nursing notes, the assessment, and implement a new intervention for safety right away, then the next day administrative staff reviewed the fall to see if the new intervention was appropriate. Staff D also stated the date of a noninjury fall would not be enough, as there</p>	F 280			

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F 280	<p>Continued From page 4 should be a new intervention on the care plan.</p> <p>On 05/10/2016 at 1:44 PM, Direct care staff O stated the resident needed cues for every step of ADLs. The resident walked with his/her walker independently, but staff kept an eye on him/her and walked beside him/her. Staff O further stated if there were new interventions, the nurses informed the direct care staff. The resident did not use the call light, but if staff asked the resident if he/she wanted to use the bathroom, he/she voiced the need and answered yes or no.</p> <p>On 05/10/2016 at 2:11 PM, Direct care staff P stated recently the resident needed more help, and he/she supervised him/her to go to the bathroom. Staff P further stated staff assisted the resident with transfers. The resident walked independently with the walker. Staff P further stated the resident had a problem with the left foot, but was not sure of the specifics of the problem. Staff P stated the resident had falls in the recent past, and the new intervention for those falls would be on the resident's care plan.</p> <p>On 05/10/2016 at 4:48 PM, License nursing staff H stated the resident was a fall risk due to having a recent decline and a fall. The resident required stand by assist for transfers at times, but was independent at times. Recently, the resident was confused and needed cues for ADLs. He/She did not use the call light, so staff had to check on him/her and ask if he/she needed to use the bathroom. Staff H further stated after a fall, the nurse completed the fall packet, updated the care plan and advised staff during report of the new intervention.</p> <p>On 05/11/2016 at 10:53 AM, Administrative</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>nursing staff D stated, after a fall the nurse on duty assessed the resident, started an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and made sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as well. Notes indicated the changes made and why.</p> <p>The facility failed to update this dependent resident's care plan who experienced multiple falls.</p> <p>- The POS (physician order sheet) for resident #110, dated and signed on 04/20/16 documented diagnoses including weakness, dementia (progressive mental disorder characterized by failing memory and confusion), and Alzheimer's (progressive mental deterioration characterized by confusion and memory failure).</p> <p>The Annual MDS (minimum data set), dated 10/21/2015, documented the resident had a BIMS (brief interview for mental status) score of 09, indicating moderately impaired cognition. The</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>resident's functional status was documented as needing supervision with transfers, walking, and locomotion on the unit. The resident needed extensive assistance with and toilet use due to unsteady balance. The resident had 2 noninjury falls since admission/entry or reentry.</p> <p>The Cognitive loss/dementia CAA (care area assessment), dated 11/12/2015, documented the resident's cognitive status put him/her at risk for falls with an expected decline due to the progression of dementia.</p> <p>The ADL (activity of daily living) Functional/Rehabilitation potential CAA, dated 11/12/2015, documented the resident's ADLs functional status triggered due to the resident's need for assistance with transfers, mobility, and locomotion. The resident normally used a 4 wheeled walker, and bent over the walker when he/she walked. He/She was at risk for falls, due to the diagnosis of dementia and weakness.</p> <p>The Falls CAA, dated 11/12/2015, documented the resident triggered for falls due to having balance problems and being at risk for falls. He/She had cognitive problems along with lower back pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), which put him/her at a risk for falls. The resident demonstrated kyphotic posture (round bank or hunchback, in which the spine in the upper back has an excessive curvature) when ambulating, and had fair to poor safety awareness. He/She also took medications which caused an increase risk for falls.</p> <p>The care plan, dated 12/15/2014, and last reviewed on 04/13/2016, directed staff to</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>encourage the resident to call for assistance with transfers and ambulation, to make sure the resident wore nonskid shoes while walking, and there were nonskid strips in the bathroom/toilet area. Staff were directed to offer the resident to be toileted at 5:30 AM, and placed a star on the resident's door to indicate fall risk. The care plan documented updates on 01/01/2015 directing staff to offer to straighten up the resident's room and bed after supper. The update on 09/02/2015 directed staff to put newer shoes on the resident. The update on 04/30/2016 directed staff to aid the resident in transfer training with a restorative plan.</p> <p>The care plan lacked interventions for falls documented in the fall investigations date 08/27/2015, 09/17/2015, 09/22/2015, 02/27/2016, 03/06/2016 and 04/09/2016.</p> <p>The fall investigation for the fall on 08/27/2015 at 4:00 PM noted the resident sustained an injury due to a fall. He/she obtained a skin tear to the left forearm, which measured 3/8 inches by 1/2 inch with bruising under the skin tear. The resident stood by the bed, lost his/her balance while turning, which caused him/her to fall backwards and land on his/her left hip and bottom. This was a witnessed fall by the nurse from the door way.</p> <p>The fall investigation dated 09/02/2015, documented a noninjury fall at 10:00 AM. The resident stood up to go to the beauty shop. The resident stated his/her feet slipped and he/she sat down on the floor.</p> <p>The fall investigation, dated 09/17/2015 at 2:55 PM, documented the resident stated he/she</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>collapsed in his/her room, then scooted to the door to get the staff's attention.</p> <p>The fall investigation, dated 09/22/2015 at 10:45 PM, documented a noninjury fall. When staff answered the resident's call light, staff found the resident on the floor by the bed. The resident stated he/she was sleeping and woke up on the floor.</p> <p>The fall investigation, dated 02/27/2016 at 9:30 PM, documented a fall without injury. The resident was sitting on the floor with his/her legs bent to the right in front of the chair. The resident stated he/she was bending over to pet the cat and sat down on the floor.</p> <p>The fall investigation, dated 03/06/2016, documented a noninjury fall. When answering the resident's call light, staff found the resident laying on the floor with the walker laying on it's side. The resident stated he/she was not sure what happened, as he/she was walking, turned and fell.</p> <p>The fall investigation, dated 04/09/2016 at 3:20 PM, documented a noninjury fall. Staff found him/her laying on the floor. The resident stated he/she was trying to go to the bathroom.</p> <p>Observation on 05/09/2016 at 8:31 AM, revealed the resident sat in the chair in his/her room, eating breakfast. He/she wore shoes on his/her feet.</p> <p>Observation on 05/09/2016 at 3:24 PM revealed the resident sat in the chair in his/her room. The resident advised he/she wanted to use the bathroom and then lay down in the bed. While</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>Direct care staff P put on gloves, the resident independently stood up from the chair, used the front wheeled walker to walk to the bathroom, and sat down on the toilet. Staff P stood by as the resident walked to the bathroom, and gave cues to step closer to the toilet prior to sitting down.</p> <p>Observation on 05/10/2016 at 7:45 AM revealed the resident sat in his/her chair in his/her room. The resident stood up independently and walked to the window. He/she used the front wheeled walker and looked out the window. The resident turned around, walked to the area by the bathroom door, put away a basket of hygiene products, and went to the bathroom. At 7:52 AM, the resident walked around in his/her room by the bed, the resident advised he/she liked to straighten up the bed. The resident further advised he/she was independent and could walk around the room as long as he/she was careful and used the furniture and the walker to walk around the room.</p> <p>On 05/09/2016 at 3:56 PM, Direct care staff P stated the resident fell occasionally, so the nurses advised direct care staff to ask the resident if he/she needed help with something more frequently. Staff P further stated staff prompted the resident to go to the toilet, offered the resident to lay down, or get up to prevent the resident from doing so by himself/herself.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D stated, after a fall the nurse on duty assessed the resident, started an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and made sure the</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as well. Notes indicated the changes made and why.</p> <p>On 05/10/2016 at 9:46 AM, Administrative staff D stated the residents were assessed on admission to see if they were a fall risk. The facility does not use a scored fall risk assessment, but used fall risk factors. Staff wrote a care plan based on those factors at admission and quarterly. Staff D expected nursing staff to put a new intervention in place on the resident's care plan after each fall. Staff D further stated he/she expected the nurses to start the nursing notes, the assessment, and implement a new intervention for safety right away, then the next day administrative staff reviewed the fall to see if the new intervention was appropriate. Staff D also stated the date of a noninjury fall would not be enough of an intervention, as there should be a new intervention on the care plan.</p> <p>On 05/10/2016 at 4:48 PM, License nursing staff H stated, after a fall, the nurse completed the fall packet, which included updating the care plan with a new intervention and informed staff during report of the change in the interventions.</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>On 05/11/2016 at 9:57 AM, Administrative nursing staff E stated, when a fall occurred, the charge nurse completed the fall packet, obtained vitals signs, did an assessment, ensured the resident was safe, updated the care plan with the new intervention, and advised the staff of the new intervention. Staff E further advised he/she reviewed the new intervention and made sure it was appropriate for the resident. He/she stated the resident had falls on 08/27/2015, 09/02/2015, 09/17/2015, 09/22/2015, 09/17/2015, 02/27/2016, 03/06/2016, and 04/09/2016. All investigations were done, but for the fall on 08/27/2015, the new intervention was not on the care plan. Staff E stated for the fall on 02/27/2016, no new intervention was on the care plan. For the fall on 03/06/2016, staff requested new shoes; however, Staff E was unsure which shoes or if this was done, as there was no documentation to direct staff not to use or wear certain shoes. Staff E confirmed for the fall on 04/09/2016 there was no documentation of a new intervention on the care plan.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D stated, after a fall, the nurse was expected to assess the resident, start an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and making sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as well. Notes indicated the changes made and why.</p> <p>The facility failed to update this dependent resident's care plan who experienced multiple falls.</p> <p>- The POS (physician order sheet) for resident #141, dated and signed on 04/18/2016, documented the following diagnosis of aortic stenosis (diseased, narrowed opening of a heart valve).</p> <p>The Annual MDS (minimum data set), dated 09/03/2015, documented the BIMS (brief interview for mental status) score of 12, which indicated the resident's cognition was intact. The resident's functional status documented the resident needed limited assistance with bed mobility, transfers, walking, locomotion, and toilet use.</p> <p>The Cognitive Loss/Dementia CAA (care area assessment), dated 09/08/2015, documented the resident had a diagnosis of mild vascular dementia (progressive mental disorder characterized by failing memory, confusion).</p> <p>The ADL (activities of daily living) functional Rehabilitation Potential, dated 09/08/2015, documented the ADLs area triggered due to his/her decline in functional abilities secondary to</p>	F 280			

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F 280	<p>Continued From page 13</p> <p>cardiac issues of aortic stenosis, hypertension (high blood pressure), severe arthritis (inflammation of a joint characterized by pain, swelling ,heat, redness and limitation of movement) to both knees, which limited his/her ability to participate fully in ADLs, as well as memory problems, which also limited the resident's ability to learn and function with ADLs.</p> <p>The Falls CAA, dated 09/08/2015, documented this area triggered due to the resident's balance problems, secondary to severe arthritis to the bilateral knees, weakness and cardiac conditions of aortic stenosis, hypertension, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), and hyperlipdemia (condition of elevated blood lipid levels).</p> <p>The care plan, dated 09/17/2015, directed the staff to anticipate the resident's needs, such as bathroom issues, eating, and grooming, to keep the resident's call light in reach, and remind the resident to call for assistance with transfers and ambulation. The care plan lacked interventions for the falls documented in the fall investigations on 03/21/2016 and 04/26/2016</p> <p>The fall investigation, dated 03/21/2016 at 4:20 PM, documented an unwitnessed non-injury fall in the resident's room. Staff found the resident on the floor. The resident advised he/she was not sure what caused the fall, as one minute he/she was on the toilet and the next the resident was on the floor.</p> <p>The fall investigation, dated 04/26/2016 at 6:10 PM, documented a noninjury fall in the resident's room. Staff found the resident sitting on the floor</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>beside his/her bed. The resident advised he/she got out of the bed, attempted to get into the wheelchair, when he/she fell.</p> <p>Observation on 05/09/2016 at 3:26 PM, the resident laid in bed, scooted independently to the edge of the bed, and staff P assisted the resident to swing his/her feet/legs off of the bed and transferred him/her to the wheelchair with a gait belt.</p> <p>Observation on 05/09/2016 at 8:03 AM, the resident sat in the dining room in the wheelchair. He/She was brought from the dining room by direct care staff O to the resident's room. Staff O asked the resident if he/she wanted to use the bathroom, but the resident refused. The resident refused to use the bathroom after being asked several times by staff, and did not want to walk or transfer to bed, recliner or couch.</p> <p>Observation on 05/10/2016 at 1:38 PM, revealed the resident was assisted to the toilet by direct care staff O. The resident used the toilet riser handles on each side to stand from the toilet independently, and was steady while pericare was performed. Staff O instructed the resident to use the wheelchair arms to steady self while turning to sit in the wheelchair. He/She followed the instructions given by staff.</p> <p>On 05/09/2016 at 3:26 PM, Direct care staff P stated the resident was a one person assist with gait belt, but would push away from staff, which made it difficult. The resident did not walk independently. Staff P further stated when there was a change on the care plan, physical therapy staff or the nurse advised the direct care staff about the change. Staff heard the changes in</p>	F 280			

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F 280	<p>Continued From page 15 report on the next shift.</p> <p>On 05/09/2016 at 8:00 AM, Direct care Staff O stated that the resident was able to make his/her needs known, but had some confusion. The resident required one person assist with a gait belt for transfers and mobility. Staff O further stated staff know how to care for the residents from the care plan, which was kept in a book at the nurse's desk in each hall. Staff looked at the care plan to see what care or assistance was needed for the resident. When there were changes, the prior shift passed it on in report. Also, the nurses advised the staff when there was a change in the resident's care plan.</p> <p>On 05/10/2016 at 9:46 AM, Administrative staff D advised the residents were assessed on admission to see if they were a fall risk. The facility does not use a scored fall risk assessment, but used fall risk factors. Staff wrote a care plan based on those factors at admission and quarterly. Staff D expected nursing staff to put a new intervention in place on the resident's care plan after each fall. Staff D further stated he/she expected the nurses to start the nursing notes, the assessment, and implement a new intervention for safety right away, then the next day administrative staff reviewed the fall to see if the new intervention was appropriate. Staff D also stated the date of a noninjury fall would not be enough of an intervention, as there should be a new intervention on the care plan.</p> <p>On 05/10/2016 at 4:48 PM, License nursing staff H stated, the resident was, at times, a one person assist, with a gait belt, and was mobile in his/her wheelchair independently. When staff did not know if the resident was a fall risk or not, then</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>they referred to the care plan. Staff H further advised after a fall, the nurse completed the fall packet, updated the care plan, and advised staff during report of the new intervention.</p> <p>On 05/11/2016 at 9:57 AM, Administrative nurse E stated when a fall occurred, the charge nurse completed the fall packet, obtained vital signs, did an assessment, made sure the resident was safe, updated the care plan with the new intervention, and advised the staff of the new intervention. Staff E stated he/she reviewed the care plan, made sure there was a new intervention, and it was appropriate. If the intervention was not appropriate, Staff E would change the intervention. Staff E further stated the resident had a fall on 03/21/2016, but the care plan lacked interventions for this fall.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D stated after a fall, the nurse was expected to assess the resident, start an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and making sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as</p>	F 280			

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F 280	Continued From page 17 well. Notes indicated the changes made and why.  The facility failed to update this dependent resident's care plan who experienced multiple falls.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: The facility identified a census of 94 residents. The sample included 18 residents with one resident sampled for review for hospice. Based on observation, record review, and staff interview, the facility failed to coordinate services with a hospice company for resident #118.  Findings included:  - The physician's progress noted dated 3/30/16 for resident #118 documented a diagnosis of dementia ( a progressive mental disorder characterized by failing memory, confusion).  The Significant Change Minimum Data Set (MDS) dated 4/29/16 noted the resident had short term and long term memory problems with moderately impaired cognitive skills for decision	F 309			

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F 309	<p>Continued From page 18</p> <p>making; had a diagnosis which resulted in a life expectancy of less than 6 months, and received hospice care.</p> <p>The Care Area Assessments (CAAs) dated 4/29/16 documented the resident displayed confusion and disorientation to his/her surroundings.</p> <p>The care plan dated 4/1/16 noted staff allowed the resident time to make decisions, explained all procedures prior to starting, and provided cuing and prompting as needed. The care plan was updated on 4/22/16 for staff to assist with the grieving process. The hospice social worker was to assess the need for a referral to a chaplain and a psychologist. The care plan lacked direction to facility staff regarding what services and supplies hospice provided for the resident.</p> <p>Review of a physician's order dated 4/22/16, noted to transfer the resident's care to a hospice provider.</p> <p>On 5/9/16 at 12:17 PM, the resident was propelled in a wheelchair down the hall by a staff.</p> <p>On 5/11/16 at 10:01 AM, direct care staff Q stated the resident received hospice services, but was unsure of the items in which hospice provided to care for the resident.</p> <p>On 5/10/16 at 5:04 PM, licensed nursing staff I stated the resident did not receive hospice services.</p> <p>On 5/11/16 at 10:24 AM, administrative nursing staff D stated the hospice staff gave a report to the charge nurse. He/she said the services and</p>	F 309			

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F 309	Continued From page 19 supplies the hospice company provided for the resident should be on the care plan.  The facility provided policy "Residents Receiving Hospice Care", dated 8/1/09, documented the facility was aware of the hospice company's responsibilities.  The facility failed to coordinate services with a hospice company for this cognitively impaired resident who received hospice services, affecting the quality of care received by this dependent resident.	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: The facility identified a census of 94 residents, and the sample size was 18. Based on observation, interview and record review, the facility failed to provide adequate restorative services to resident #59 to maintain his/her highest level of Activity of Daily Livings (ADLs) function.  Findings included:  - The signed Physician's Order Sheet dated	F 318			

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F 318	<p>Continued From page 20</p> <p>4/18/16 for resident #59 listed diagnoses of dementia (a decline in mental ability interfering with daily life) and ataxia (impaired ability to coordinate movements).</p> <p>The annual Minimum Data Set (MDS) dated 7/2/15 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 3 (less than 7 indicated severely impaired cognition). The resident required extensive assistance with transfers. He/she had an unsteady gait and limited range of motion in one arm. He/she used a walker and a wheelchair for mobility. He/she had 2 or more non-injury falls prior to the assessment.</p> <p>The quarterly MDS dated 3/10/16 revealed the resident had BIMS score of 7. The resident required extensive assistance with transfer. The resident had an unsteady gait and limited range of motion in one arm. He/she used walker and a wheelchair. He/she had 2 or more non-injury falls prior to assessment. The resident received occupational therapy, physical therapy and was on a restorative program for range of motion, transfers and walking.</p> <p>The Care Area Assessments (CAA) dated 7/3/15 noted the resident had a diagnosis of dementia, ataxia and weakness, and required assistance with Activities of Daily Livings (ADLs) due to poor safety awareness and cognitive impairment. A restorative program was developed to maintain the resident's ADL function.</p> <p>The care plan initiated 8/7/14 revealed the resident needed assistance with his/her cares, and used a walker to ambulate. The restorative staff was to walk with him/her 5 to 6 times weekly.</p>	F 318			

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F 318	<p>Continued From page 21</p> <p>The updates, on 6/12/15, 7/14/15 and 2/21/16 revealed the resident ambulated with a walker and was on a restorative nursing program to improve ambulation.</p> <p>The fall Investigation Reports noted the resident had a fall on 11/14/15. The interventions included the resident continued with the restorative therapy program.</p> <p>The restorative Monthly Summary Detail Report dated 2/12/16 revealed the resident had only participated in the restorative program for 6 out of 24 sessions in the past month.</p> <p>Review of Resident Restorative Chart from 2/1/16 to 5/10/16 documented the resident received restorative services for transfers and ambulation. The resident had not received restorative services more than 4 times. Total out of 10 weeks, there was 1 week the resident did not receive any session of the restorative services during the week, there were 3 weeks the resident only received the services once in a 7-day period, and there were 4 weeks the resident only received 2 times in a 7- day period.</p> <p>Observation on 05/10/16 at 7:47 AM revealed direct care staff R and S transferred the resident to his/her recliner from the wheelchair. His/her gait was stiff and unsteady.</p> <p>On 05/10/16 at 9:56 AM, direct care staff R stated the resident had an unsteady gait, and the resident required assistance with transfers and ambulation.</p> <p>On 05/10/16 at 3:31 PM, direct care staff S stated the resident was on restorative program. The</p>	F 318			

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F 318	Continued From page 22 restorative aids were available 7 days a week giving the resident an opportunity to receive restorative services for the 6 days a week that had been care planned for the resident.  On 05/10/16 at 11:46: AM, administrative nursing staff F stated the resident had weakness and the restorative staff should work with him/her 5 to 6 times a week for how to transfer and for lower extremities strengthening.  On 05/10/2016 at 3:22 PM, administrative nursing staff F stated there was not a restorative assessment completed for the resident since 2014, and the assessment should be conducted at least quarterly and as needed.  On 05/10/2016 at 4:59 PM, administrative nursing staff D stated he/she was not aware the resident was not receiving adequate restorative exercise or the restorative assessments.  The facility's Implementing Restorative Nursing Program policy revised 10/1/15 documented a restorative program must be provided 6 out of 7 days per week. Monthly reviews and any changes to the program by a licensed nurse must be documented in the record and updated on the care plan.  The facility failed to provide adequate restorative services to ensure this cognitively impaired resident reached and maintained his/her highest level of range of motion.	F 318			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident	F 323			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 23</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 94 residents, with a sample of 18 residents, including 4 residents reviewed for accidents. Based on observation, record review and interview, the facility failed to develop and implement timely and effective interventions to prevent falls for 4 (#59, #86, #110, and #141) of the 4 residents sampled for falls, each with repeated falls.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The POS (physician order sheet) for resident #86, dated and signed on 03/19/2016, documented diagnoses including moderate dementia (progressive mental disorder characterized by failing memory, confusion), a history of falls, and syncope (fainting, loosing consciousness).</li> </ul> <p>The Annual MDS (minimum data set), dated 07/29/2015, documented the resident had a BIMS (brief interview for mental status) score of 12, which indicated moderately impaired cognition. The resident's functional status was documented as independent with bed mobility, transfers, walking in room, dressing, and toilet use. The resident needed supervision with walking in the corridor, locomotion and personal hygiene.</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>The Cognitive loss/dementia CAA (care area assessment), dated 08/03/2015, documented the resident had a diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) disease, and a BIMS score of 12, which indicated moderately impaired cogitation.</p> <p>The ADL (activities of daily living) functional/Rehabilitation potential CAA, dated 08/03/2015, documented the resident was able to perform ADLs, some with supervision due to the diagnosis of dementia and continued decline.</p> <p>The Falls CAA, dated 08/03/2015, documented the resident had long and short term memory deficits. The resident used a walker for stability, sight supervision to monitor for changes in function, and took medications which had a potential to cause falls.</p> <p>The care plan, dated 09/08/2014, and reviewed on 04/13/2016, directed the staff to help the resident keep his/her room decluttered, notify the nurse when the resident experienced changes in his/her gait or ability to transfer, keep the call light within reach, check on the resident at least every 2 hours when the resident was in his/her room, place nonskid strips in front of the closet, remind the resident not to drag his/her feet when walking, and to keep the walker close.</p> <p>The care plan lacked interventions for the falls, documented in the fall investigations, on 10/04/2015, 12/15/2015, 04/29/2016 and 05/04/2016.</p> <p>The fall investigation, dated 10/04/2015 at 7:15 PM, documented a witnessed fall when the</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>resident ambulated in the hallway with his/her walker. The resident took a step forward, but the other foot didn't follow, which caused the resident to lose his/her balance and to fall to the floor, landing on the right side.</p> <p>The fall investigation, dated 12/15/2015 at 2:20 PM, documented an unwitnessed noninjury fall as the resident was found in his/her room attempting to use the bed to raise him/her up off the floor.</p> <p>The fall investigation, dated 04/29/2016 at 6:15 AM, documented an unwitnessed, noninjury fall. The resident was found on the floor in his/her room. The witness statement documented the resident was sat on the floor, and was undressed from the waist down. The chair cushion was on the floor next to the resident, and a wet brief laid on the floor.</p> <p>The fall investigation, dated 05/04/2016 at 12:10 AM, documented the resident was found on the floor. The resident was unsure of what happened to cause the fall.</p> <p>Observation on 05/09/2016 at 8:12 AM revealed the resident walked down the hall independently with his/her walker, gait slow and steady.</p> <p>Observation on 05/09/2016 at 9:17 AM revealed the resident walked down the hall independently with the walker, and was reminded by the staff to pick up his/her feet and not drag them.</p> <p>Observation on 05/09/2016 at 3:45 PM revealed the resident sat in the chair in his/her room with the walker within his/her reach. The resident was wearing one boot. The resident used the walker to stand up independently, took a few steps</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>across the room, and sat down on the bed. At 3:48 PM, the resident walked down the hall independently with the walker. He/she wore one boot on the left foot and the right foot was bare.</p> <p>On 05/10/2016 at 9:46 AM, Administrative staff D stated the residents were assessed on admission to see if they were a fall risk. The facility does not use a scored fall risk assessment, but used fall risk factors. Staff wrote a care plan based on those factors at admission and quarterly. Staff D expected nursing staff to put a new intervention in place on the resident's care plan after each fall. Staff D further stated he/she expected the nurses to start the nursing notes, the assessment, and implement a new intervention for safety right away, then the next day administrative staff reviewed the fall to see if the new intervention was appropriate. Staff D also stated the date of a noninjury fall would not be enough, there should be a new intervention on the care plan.</p> <p>On 05/10/2016 at 1:44 PM, Direct care staff O stated the resident needed cues for every step of ADLs. The resident walked with his/her walker independently, but staff kept an eye on him/her and walked beside him/her. Staff O further stated if there were new interventions, the nurses informed the direct care staff. The resident did not use the call light, but if staff asked the resident if he/she wanted to use the bathroom, he/she voiced the need and answered yes or no.</p> <p>On 05/10/2016 at 2:11 PM, Direct care staff P stated recently the resident needed more help, and he/she supervised him/her to go to the bathroom. Staff P further stated staff assisted the resident with transfers. The resident walked independently with the walker. Staff P further</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>stated the resident had a problem with the left foot, but was not sure of the specifics of the problem. Staff P stated the resident had falls in the recent past, and the new intervention for those falls would be on the resident's care plan.</p> <p>On 05/10/2016 at 4:48 PM, License nursing staff H stated the resident was a fall risk due to having a recent decline and a fall. The resident required stand by assist for transfers at times, but was independent at times. Recently, the resident was confused and needed cues for ADLs. He/She did not use the call light, so staff had to check on him/her and ask if he/she needed to use the bathroom. Staff H further stated after a fall, the nurse completed the fall packet, updated the care plan and staetd staff during report of the new intervention.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D stated, after a fall the nurse on duty assessed the resident, started an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and made sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>well. Notes indicated the changes made and why.</p> <p>The facility failed to implement timely and effective interventions to prevent further falls for this dependent resident who had repeated falls.</p> <p>- The POS (physician order sheet) for resident #110, dated and signed on 04/20/16 documented diagnoses included weakness, dementia (progressive mental disorder characterized by failing memory and confusion), and Alzheimer's (progressive mental deterioration characterized by confusion and memory failure).</p> <p>The Annual MDS (minimum data set), dated 10/21/2015, documented the resident had a BIMS (brief interview for mental status) score of 09, indicated moderately impaired cognition. The resident's functional status was documented as needing supervision with transfers, walking, and locomotion on the unit. The resident needed extensive assistance with and toilet use due to unsteady balance. The resident had 2 noninjury falls since admission/entry or reentry.</p> <p>The Cognitive loss/dementia CAA (care area assessment), dated 11/12/2015, documented the resident's cognitive status put him/her at risk for falls with an expected decline due to the progression of dementia.</p> <p>The ADL (activity of daily living) Functional/Rehabilitation potential CAA, dated 11/12/2015, documented the resident's ADLs functional status triggered due to the resident's need for assistance with transfers, mobility, and locomotion. The resident normally used a 4 wheeled walker, and bent over the walker when</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>he/she walked. He/She was at risk for falls, due to the diagnosis of dementia and weakness.</p> <p>The Falls CAA, dated 11/12/2015, documented the resident triggered for falls due to having balance problems and being at risk for falls. He/She had cognitive problems along with lower back pain, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), which put him/her at a risk for falls. The resident demonstrated kyphotic posture (round bank or hunchback, in which the spine in the upper back has an excessive curvature) when ambulating, and had fair to poor safety awareness. He/She also took medications which caused an increase risk for falls.</p> <p>The care plan, dated 12/15/2014, and last reviewed on 04/13/2016, directed staff to encourage the resident to call for assistance with transfers and ambulation, to make sure the resident wore nonskid shoes while walking, and there were nonskid strips in the bathroom/toilet area. Staff were directed to offer the resident to be toileted at 5:30 AM, and placed a star on the resident's door to indicate fall risk. The care plan documented updates on 01/01/2015 directing staff to offer to straighten up the resident's room and bed after supper. The update on 09/02/2015 directed staff to put newer shoes on the resident. The update on 04/30/2016 directed staff to aid the resident in transfer training with a restorative plan.</p> <p>The care plan lacked interventions for falls documented in the fall investigations date 08/27/2015, 09/17/2015, 09/22/2015, 02/27/2016, 03/06/2016 and 04/09/2016.</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>The fall investigation for the fall on 08/27/2015 at 4:00 PM noted the resident sustained an injury due to a fall. He/she obtained a skin tear to the left forearm, which measured 3/8 inches by 1/2 inch with bruising under the skin tear. The resident stood by the bed, lost his/her balance while turning, which caused him/her to fall backwards and land on his/her left hip and bottom. This was a witnessed fall by the nurse from the door way.</p> <p>The fall investigation dated 09/02/2015, documented a noninjury fall on 09/02/2015 at 10:00 AM. The resident stood up to go to the beauty shop. The resident stated his/her feet slipped and he/she sat down on the floor.</p> <p>The fall investigation, dated 09/17/2015 at 2:55 PM, documented the resident stated he/she collapsed in his/her room, then scooted to the door to get the staff's attention.</p> <p>The fall investigation, dated 09/22/2015 at 10:45 PM, documented a noninjury fall. When staff answered the resident's call light, staff found the resident on the floor by the bed. The resident stated he/she was sleeping and woke up on the floor.</p> <p>The fall investigation, dated 02/27/2016 at 9:30 PM, documented a fall without injury. The resident was sitting on the floor with his/her legs bent to the right in front of the chair. The resident stated he/she was bending over to pet the cat and sat down on the floor.</p> <p>The fall investigation, dated 03/06/2016, documented a noninjury fall. When answering the resident's call light, staff found the resident</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>laying on the floor with the walker laying on it's side. The resident stated he/she was not sure what happened, as he/she was walking, turned and fell.</p> <p>The fall investigation, dated 04/09/2016 at 3:20 PM, documented a noninjury fall. Staff found him/her laying on the floor. The resident stated he/she was trying to go to the bathroom.</p> <p>Observation on 05/09/2016 at 8:31 AM, revealed the resident sat in the chair in his/her room, eating breakfast. He/she wore shoes on his/her feet.</p> <p>Observation on 05/09/2016 at 3:24 PM revealed the resident sat in the chair in his/her room. The resident stated he/she wanted to use the bathroom and then lay down in the bed. While Direct care staff P put on gloves, the resident independently stood up from the chair, used the front wheeled walker to walk to the bathroom, and sat down on the toilet. Staff P stood by as the resident walked to the bathroom, and gave cues to step closer to the toilet prior to sitting down.</p> <p>Observation on 05/10/2016 at 7:45 AM revealed the resident sat in his/her chair in his/her room. The resident stood up independently and walked to the window. He/she used the front wheeled walker and looked out the window. The resident turned around, walked to the area by the bathroom door, put away a basket of hygiene products, and went to the bathroom. At 7:52 AM, the resident walked around in his/her room by the bed, the resident stated he/she liked to straighten up the bed. The resident further stated he/she was independent and could walk around the room as long as he/she was careful and used the</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>furniture and the walker to walk around the room.</p> <p>On 05/09/2016 at 3:56 PM, Direct care staff P stated the resident fell occasionally, so the nurses advised direct care staff to ask the resident if he/she needed help with something more frequently. Staff P further stated staff prompted the resident to go to the toilet, offered the resident to lay down, or get up to prevent the resident from doing so by himself/herself.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D stated, after a fall the nurse on duty assessed the resident, started an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and made sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as well. Notes indicated the changes made and why.</p> <p>On 05/10/2016 at 9:46 AM, Administrative staff D stated the residents were assessed on admission to see if they were a fall risk. The facility does not use a scored fall risk assessment, but used fall risk factors. Staff wrote a care plan based on</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>those factors at admission and quarterly. Staff D expected nursing staff to put a new intervention in place on the resident's care plan after each fall. Staff D further stated he/she expected the nurses to start the nursing notes, the assessment, and implement a new intervention for safety right away, then the next day administrative staff reviewed the fall to see if the new intervention was appropriate. Staff D also stated the date of a noninjury fall would not be enough of an intervention, as there should be a new intervention on the care plan.</p> <p>On 05/10/2016 at 4:48 PM, License nursing staff H stated, after a fall, the nurse completed the fall packet, which included updating the care plan with a new intervention and informed staff during report of the change in the interventions.</p> <p>On 05/11/2016 at 9:57 AM, Administrative nursing staff E stated, when a fall occurred, the charge nurse completed the fall packet, obtained vitals signs, did an assessment, ensured the resident was safe, updated the care plan with the new intervention, and stated the staff of the new intervention. Staff E further stated he/she reviewed the new intervention and made sure it was appropriate for the resident. He/she stated the resident had falls on 08/27/2015, 09/02/2015, 09/17/2015, 9/22/2015, 09/17/2015, 02/27/2016, 03/06/2016, and 04/09/2016. All investigations were done, but for the fall on 08/27/2015, the new intervention was not on the care plan. Staff E stated for the fall on 02/27/2016, no new intervention was on the care plan. For the fall on 03/06/2016, staff requested new shoes; however, Staff E was unsure which shoes or if this was done, as there was no documentation to direct staff not to use or wear certain shoes. Staff E</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>confirmed for the fall on 04/09/2016 there was no documentation of a new intervention on the care plan.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D advised, after a fall, the nurse was expected to assess the resident, start an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and making sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as well. Notes indicated the changes made and why.</p> <p>The facility failed to implement timely and effective interventions to prevent further falls for this resident who had repeated falls.</p> <p>- The POS (physician order sheet) for resident #141, dated and signed on 04/18/2016, documented the following diagnosis of aortic stenosis (diseased, narrowed opening of a heart valve).</p> <p>The Annual MDS (minimum data set), dated</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>09/03/2015, documented the BIMS (brief interview for mental status) score of 12, which indicated the resident's cognition was intact. The resident's functional status documented the resident needed limited assistance with bed mobility, transfers, walking, locomotion, and toilet use.</p> <p>The Cognitive Loss/Dementia CAA (care area assessment), dated 09/08/2015, documented the resident had a diagnosis of mild vascular dementia (progressive mental disorder characterized by failing memory, confusion).</p> <p>The ADL (activities of daily living) functional Rehabilitation Potential, dated 09/08/2015, documented the ADLs area triggered due to his/her decline in functional abilities secondary to cardiac issues of aortic stenosis, hypertension (high blood pressure), severe arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement) to both knees, which limited his/her ability to participate fully in ADLs, as well as memory problems, which also limited the resident's ability to learn and function with ADLs.</p> <p>The Falls CAA, dated 09/08/2015, documented this area triggered due to the resident's balance problems, secondary to severe arthritis to the bilateral knees, weakness and cardiac conditions of aortic stenosis, hypertension, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), and hyperlipdemia (condition of elevated blood lipid levels).</p> <p>The care plan, dated 09/17/2015, directed the staff to anticipate the resident's needs, such as</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>bathroom issues, eating, and grooming, to keep the resident's call light in reach, and remind the resident to call for assistance with transfers and ambulation. The care plan lacked interventions for the falls documented in the fall investigations on 03/21/2016 and 04/26/2016</p> <p>The fall investigation, dated 03/21/2016 at 4:20 PM, documented an unwitnessed non-injury fall in the resident's room. Staff found the resident on the floor. The resident advised he/she was not sure what caused the fall, as one minute he/she was on the toilet and the next the resident was on the floor.</p> <p>The fall investigation, dated 04/26/2016 at 6:10 PM, documented a noninjury fall in the resident's room. Staff found the resident sitting on the floor beside his/her bed. The resident advised he/she got out of the bed, attempted to get into the wheelchair, when he/she fell.</p> <p>Observation on 05/09/2016 at 3:26 PM, the resident laid in bed, scooted independently to the edge of the bed, and staff P assisted the resident to swing his/her feet/legs off of the bed and transferred him/her to the wheelchair with a gait belt.</p> <p>Observation on 05/09/2016 at 8:03 AM, the resident sat in the dining room in the wheelchair. He/She was brought from the dining room by direct care staff O to the resident's room. Staff O asked the resident if he/she wanted to use the bathroom, but the resident refused. The resident refused to use the bathroom after being asked several times by staff, and did not want to walk or transfer to bed, recliner or couch.</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>Observation on 05/10/2016 at 1:38 PM, revealed the resident was assisted to the toilet by direct care staff O. The resident used the toilet riser handles on each side to stand from the toilet independently, and was steady while pericare was performed. Staff O instructed the resident to use the wheelchair arms to steady self while turning to sit in the wheelchair. He/She followed the instructions given by staff.</p> <p>On 05/09/2016 at 3:26 PM, Direct care staff P stated the resident was a one person assist with gait belt, but would push away from staff, which made it difficult. The resident did not walk independently. Staff P further stated when there was a change on the care plan, physical therapy staff or the nurse stated the direct care staff about the change. Staff heard the changes in report on the next shift.</p> <p>On 05/09/2016 at 8:00 AM, Direct care Staff O stated that the resident was able to make his/her needs known, but had some confusion. The resident required one person assist with a gait belt for transfers and mobility. Staff O further stated staff know how to care for the residents from the care plan, which was kept in a book at the nurse's desk in each hall. Staff looked at the care plan to see what care or assistance was needed for the resident. When there were changes, the prior shift passed it on in report. Also, the nurses advised the staff when there was a change in the resident's care plan.</p> <p>On 05/10/2016 at 9:46 AM, Administrative staff D stated the residents were assessed on admission to see if they were a fall risk. The facility does not use a scored fall risk assessment, but used fall risk factors. Staff wrote a care plan based on</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>those factors at admission and quarterly. Staff D expected nursing staff to put a new intervention in place on the resident's care plan after each fall. Staff D further stated he/she expected the nurses to start the nursing notes, the assessment, and implement a new intervention for safety right away, then the next day administrative staff reviewed the fall to see if the new intervention was appropriate. Staff D also stated the date of a noninjury fall would not be enough of an intervention, as there should be a new intervention on the care plan.</p> <p>On 05/10/2016 at 4:48 PM, License nursing staff H stated the resident was, at times, a one person assist, with a gait belt, and was independently mobile in his/her wheelchair. When staff did not know if the resident was a fall risk or not, then they referred to the care plan. Staff H further stated that after a fall, the nurse completed the fall packet, updated the care plan, and advised staff during report of the new intervention.</p> <p>On 05/11/2016 at 9:57 AM, Administrative nurse E stated when a fall occurred, the charge nurse completed the fall packet, obtained vital signs, did an assessment, made sure the resident was safe, updated the care plan with the new intervention, and advised the staff of the new intervention. Staff E stated he/she reviewed the care plan, made sure there was a new intervention, and it was appropriate. If the intervention was not appropriate, Staff E would change the intervention. Staff E further stated the resident had a fall on 03/21/2016, but the care plan lacked interventions for this fall.</p> <p>On 05/11/2016 at 10:53 AM, Administrative nursing staff D stated, after a fall, the nurse was</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>expected to assess the resident, start an investigation, and put a new intervention in place on the care plan. Then, the ADON (assistant director of nursing) for the unit was responsible for reviewing the fall packet and making sure the care plan was updated with an appropriate intervention for that fall.</p> <p>The facility policy, entitled Process for Care Plan Development and Communication, revision date of 09/24/2014, documented each facility shall follow a care planning process to ensure timely development and updating of the residents' plans of care. The care plan should be viewed as work in progress and changes were made as the residents' needs changed. When there was a change to the resident's care plan, there needed to be an update in the interdisciplinary notes as well. Notes indicated the changes made and why.</p> <p>The facility failed to implement timely and effective interventions to prevent further falls for this dependent resident who had repeated falls.</p> <p>- The signed Physician's Order Sheet dated 4/18/16 for resident #59 listed diagnoses of dementia (a decline in mental ability interfering with daily life), urinary retention (lack of the ability to urinate and empty the bladder) and ataxia (impaired ability to coordinate movements).</p> <p>The Annual MDS (Minimum Data Set) dated 7/2/15 revealed the resident had BIMS (Brief Interview for Mental Status) score of 3 (less than 7 indicated severely impaired cognition). The resident required extensive assistance with transfers. He/she had an unsteady gait and limited range of motion in one arm. He/she used</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>walker and a wheelchair for mobility. He/she had 2 or more non-injury falls prior to the assessment.</p> <p>The quarterly MDS dated 3/10/16 revealed the resident had a BIMS score of 7. The resident required extensive assistance with transfers. The resident had unsteady gait and limited range of motion in one arm. He/she used a walker and a wheelchair for mobility. He/she had 2 or more non-injury falls prior to assessment. The resident received occupational therapy, physical therapy and was on a restorative program for range of motion, transfers and walking.</p> <p>The Care Area Assessments (CAA) dated 7/3/15 noted the resident had a diagnosis of dementia, ataxia and weakness, and required assistance with Activity of Daily Living (ADLs) due to poor safety awareness and cognitive impairment.</p> <p>The care plan initiated 8/7/14 revealed the resident needed assistance with his/her cares, and used a walker to ambulate. The updates, on 6/12/15, 7/14/15 and 2/21/16 revealed the resident was at risk for falls related to poor safety awareness and cognitive impairment. Staff should offer him/her to be placed in his/her recliner with a call light within reach. The resident should have a fall mat beside his/her bed and in front of the recliner. The resident had limited range of motion, so staff provided the appropriate level of assistance to promote the safety of the resident.</p> <p>The Fall Investigation Reports dated 2/21/16 noted the resident had a fall. The interventions included the resident was referred to the therapy and staff should place a fall mat in front of the recliner.</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>Rehab Referral and Screen Outcome Form dated 2/21/16 revealed the resident did not need an evaluation at this time for recent incidents.</p> <p>The Fall Investigation Reports dated 3/31/16 and 4/16/16 noted the resident fell. The intervention for each of these falls was to continue current care plan.</p> <p>Observation on 05/09/16 at 3:39 PM revealed the resident rested in the recliner in the room. His/her call light was on the bed and not within reach as directed by the care plan and the fall mat was folded up under the bed and not in front of the recliner as directed by the care plan.</p> <p>Observation on 05/10/16 at 7:47 AM revealed direct care staff R and S transferred the resident to his/her recliner from the wheelchair. The fall mat was not placed in front of the recliner by the staff as directed by the care plan, before staff R and S left the room.</p> <p>Observation on 05/10/16 at 3:55 PM revealed the resident sat in his/her recliner. The call light was on the bed and not within reach of the resident as directed by the care plan.</p> <p>On 05/10/16 at 9:56 AM, direct care staff R stated the resident had an unsteady gait. Staff kept the call light within the resident's reach and placed the fall mat next to the bed or chair when the resident was in them.</p> <p>On 05/10/16 at 3:53 PM, direct care staff T stated the resident was at risk for falls. He/she said the resident frequently forgot to use the call light.</p> <p>On 05/10/16 at 10:24 AM, licensed nursing staff J</p>	F 323			

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F 323	Continued From page 42 stated the fall mat should be placed by the recliner. The resident had used the call light before, but he/she was often forgetful and confused.  On 05/10/2016 at 4:59 PM, the administrative nursing staff D stated he/she was not aware staff was not following the care plan by placing the call light in reach of this resident when he/she was in the room and by placing the fall mat in front of the recliner.  The facility's Fall Management Investigation Program policy, revised 10/15/11, documented the interventions after a fall would be reviewed with the staff and the resident for compliance.  The facility failed to place appropriate interventions after falls and follow the care planned interventions to prevent falls for this cognitively impaired resident with repeated falls.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329			

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F 329	<p>Continued From page 43</p> <p>therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 94 residents. The sample was 18 residents, with 5 residents sampled for medication review. Based on observation, record review and interview, the facility failed to monitor for the side effects of medications for residents #7, #85 and #118, and failed to monitor the effectiveness of medications for resident #118.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The physician's progress note for resident #118 dated 3/30/16 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).</li> </ul> <p>The Physician's Order Sheet for April 2016 noted orders for Depakote (a medication to stabilize the mood) 250 milligrams (mg) by mouth twice a day and Docusate sodium (a stool softener) 200 mg by mouth twice a day.</p> <p>The clinical record lacked orders for any as needed medications for constipation (difficulty passing a bowel movement).</p>	F 329			

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F 329	Continued From page 44  The Significant Change Minimum Data Set (MDS) dated 4/29/16 noted the resident had short term and long term memory problems with moderately impaired cognitive skills for decision making. He/she did not exhibit behavioral symptoms.  The Care Area Assessments (CAAs) dated 4/29/16 documented the resident displayed confusion and disorientation to his/her surroundings. The resident cried out, "Help, help", but was unable to communicate a specific need.  The care plan dated 4/1/16 noted staff allowed the resident time to make decisions, explained all procedures prior to starting, and provided cuing and prompting as needed. The target behavior was the resident called out, "Help me".  Bowel movement records for April 2016 noted the resident did not have a bowel movement from 4/5/16 until 4/10/16 (5 days), from 4/10/16 until 4/15/16 (5 days), from 4/17/16 until 4/22/16 (5 days), and from 4/25/16 until 5/2/16 (7 days).  According to the U.S. Food and Drug Administration, the side effects of Depakote included constipation.  On 5/9/16 at 12:17 PM, the resident sat in a wheelchair in the hall. He/she waved and smiled at staff.  On 5/10/16 at 5:54 PM, direct care staff V stated staff documented bowel movements when the resident had one, and the nurse received a list of residents every day who had not had a bowel movement within 3 days. Staff V said the nurses	F 329			

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F 329	<p>Continued From page 45 acted upon the list.</p> <p>On 5/10/16 at 5:06 PM, licensed nursing staff I stated stated the direct care staff charted when a resident had a bowel movement. The administrative nursing staff generated a list of residents who had not had a bowel movement in 3 days from the Care Tracker (where the bowel movements were documented). He/he confirmed the list with the direct care staff, and then gave an as needed laxative per the physician's orders.</p> <p>On 5/11/16 at 10:20 AM, administrative nursing staff D confirmed there was a lack of monitoring of the resident's bowel movements and there was a system failure.</p> <p>The facility's policy "Bowel Management Interventions", dated 1/1/01, noted staff were to monitor medication use carefully.</p> <p>The facility failed to monitor the effectiveness of a medication for behaviors, and failed to monitor for medication side effects. This could potentially cause harm to this cognitively impaired resident.</p> <p>Furthermore, the facility failed to monitor resident #118's target behaviors in March 2016.</p> <p>The Physician's Order Sheet for April 2016 noted orders for Depakote (a medication to stabilize the mood) 250 milligrams (mg) by mouth twice a day.</p> <p>The Significant Change Minimum Data Set (MDS) dated 4/29/16 noted the resident had short term and long term memory problems with moderately impaired cognitive skills for decision making. He/she did not exhibit behavioral symptoms.</p>	F 329			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 46</p> <p>The Care Area Assessments (CAAs) dated 4/29/16 documented the resident displayed confusion and disorientation to his/her surroundings. The resident cried out, "Help, help", but was unable to communicate a specific need.</p> <p>The care plan dated 4/1/16 noted staff allowed the resident time to make decisions, explained all procedures prior to starting, and provided cuing and prompting as needed. The target behavior was the resident called out, "Help me".</p> <p>The clinical record lacked monitoring of targeted behaviors for March 2016.</p> <p>On 5/9/16 at 9:55 AM, the resident called out, "Help me, help me".</p> <p>On 05/09/2016 at 3:19 PM, licensed nursing staff M advised when a resident had behaviors, nursing staff charted them in the clinical record.</p> <p>On 05/09/2015 at 3:49 PM, direct care staff W stated when he/she saw behaviors, he/she reported them to the nurse and the nurse charted the behaviors.</p> <p>On 5/10/16 at 11:52 AM, administrative nursing staff G stated he/she expected staff to monitor the resident's behavior as the resident received Depakote. He/She confirmed there was a lack of behavior monitoring for the resident for March 2016.</p> <p>On 5/10/16 at 5:06 PM, licensed nursing staff I stated the resident repeatedly asked questions and frequently yelled, "Help me". He/she said staff redirected the resident with the interventions</p>	F 329			

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F 329	<p>Continued From page 47</p> <p>on the behavior monitoring form in the resident's clinical record.</p> <p>On 5/10/16 at 5:54 PM, direct care staff V stated the resident frequently yelled, "Help me".</p> <p>The facility's policy "Medication Management Guidelines", dated 5/28/12, noted an adverse drug reaction was an undesirable effect of a drug which is different from the intended effect. The physician would be notified of an adverse drug reaction.</p> <p>The facility's policy "Psychopharmacological Medication", dated 10/30/01, revealed staff were to assess the resident's response to treatment and care.</p> <p>The facility failed to monitor the effectiveness of a medication this cognitively impaired resident received for behaviors.</p> <p>- The signed Physician's Order Sheet (POS) dated 4/25/2016 listed resident #7 had diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</p> <p>Resident #7's admission Minimum Data Set (MDS) dated 3/30/16 revealed the resident had Brief Interview Mental Status (BIMS) score of 15 indicated intact cognition. The resident required extensive assistance with toileting use and personal hygiene. The resident received scheduled and as needed pain medications.</p> <p>The Care Area Assessment (CAA) dated 4/3/16 revealed the resident required extensive assistance with his/her transfers and toileting. The resident was alert and oriented, and he/she</p>	F 329			

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F 329	<p>Continued From page 48 made her needs known.</p> <p>The care plan dated 4/5/16 revealed nursing staff documented when the resident had a bowel movement.</p> <p>Review of the signed physician order dated 3/23/16 revealed the resident received morphine sulfate ER (extended release) (used for moderate to severe pain) 30 mg (milligrams) 1 tablet every 12 hours, and oxycodone IR (Immediate release) (used for moderate to severe pain) 5 mg 2 tablets every 6 hours as needed.</p> <p>The U.S. Food and Drug Administration recommendations revealed the side effects of morphine and oxycodone included constipation.</p> <p>Review of Bowel Detailed Entry Report from March 2016 to May 2016 documented the resident had not had a bowel movement from 3/28/16 until 4/2/16 (5 days), from 4/7/16 until 4/11/16 (4 days), from 4/19/16 until 4/25/16 (6 days) and from 4/26/16 until 5/1/16 (5 days).</p> <p>Review of the Medication Administration Record from March to May 2016 noted the resident did not receive any order of as needed medications for constipation.</p> <p>Observation on 05/11/2016 at 7:44 AM, direct care staff Q and R transferred the resident to the toilet.</p> <p>During an interview on 05/09/2016 at 2:25 PM, the resident stated he/she was constipated, and needed staff's assistance with toileting.</p> <p>During an interview on 05/09/2015 at 3:49 PM,</p>	F 329			

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F 329	<p>Continued From page 49</p> <p>direct care staff W stated all direct care staff should chart bowel movements every shift.</p> <p>During an interview on 05/10/2016 at 10:07 AM, direct care staff R confirmed the resident had constipation.</p> <p>During an interview on 05/10/2016 at 1:44 PM, licensed nursing staff K stated the direct care staff documented the bowel movements and the nurses should obtain orders from the physicians for as needed medications.</p> <p>During an interview on 05/11/2016 at 7:42 AM, licensed nursing staff M stated the nurses received a list of residents who had not had a bowel movement for more than 3 days which staff was to act upon. However, there was not a physician 's standing order for medications to treat constipation.</p> <p>During an interview on 05/11/2016 at 10:20 AM, administrative nursing staff D confirmed there was a system failure of monitoring for bowel movements.</p> <p>The facility's Medication Management Guidelines policy dated 5/28/2002 documented the licensed nurse should implement the physician's instructions for monitoring and report adverse drug reactions.</p> <p>The facility failed to monitor the constipating side effects of the medications for this resident.</p> <p>- The Physician's Order Sheet (POS) dated 4/20/2016 listed resident #85 had diagnoses of aphasia (condition with disordered or absent language function), cerebrovascular accident</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>(sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The signed physician's order dated 4/25/2016 revealed the resident received mirtazapine (used for depression) 12 milligrams (mg) 1 tablet daily.</p> <p>The annual Minimum Data Set (MDS) dated 11/19/15 revealed the resident had short and long term memory problems and severely impaired cognition. The resident required assistance with transfer and toileting. He/she was always incontinent with bowel movements.</p> <p>The quarterly MDS dated 2/11/16 revealed the resident had short and long term memory problems and severely impaired cognition. The resident required assistance with transfer and toileting. He/she was always incontinent with bowel movements.</p> <p>The Care Area Assessments (CAAs) dated 12/2/15 revealed the resident had diagnoses of cerebrovascular accident and depression. Staffs provided assistance with his/her Activities of Daily Living (ADLs) to prevent complications associated with incontinence, and monitor for adverse side effects of the antidepressant.</p> <p>The care plan dated 12/18/14 revealed the resident received antidepressants and the staff was to monitor the potential side effects of his/her antidepressant medication. The resident had cognitive impairment and staff was to provide assistance with transfer and toilet use.</p>	F 329			

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F 329	<p>Continued From page 51</p> <p>According to U.S. Food and Drug Administration recommendations, the side effects of mirtazapine included constipation.</p> <p>Review of Bowel Detailed Entry Report from March to May 2016 revealed the resident had not had a bowel movement from 3/23/16 until 3/28/16 (5 days), from 3/29/16 until 4/2/16 (4 days), from 4/4/16 until 4/10/16 (6 days), from 4/17/16 until 4/23/16 (6 days), and from 4/24/16 until 4/28/16 (4 days).</p> <p>Review of Medication Administration Record (MAR) from March 2016 to May 2016 noted the resident had received Milk of Magnesia 15 milliliters (ml) as needed once in the month of March (the staff was unable to determine the hand written date on the MAR).</p> <p>Observation on 05/09/2016 at 11:25 AM, the resident sat in his/her wheelchair and attended group exercise in the day room.</p> <p>During an interview on 05/09/2015 at 3:49 PM, direct care staff W stated all direct care staff should chart bowel movements every shift.</p> <p>During an interview on 05/10/2016 at 10:07 AM, direct care staff R confirmed the resident had constipation.</p> <p>During an interview on 05/10/2016 at 1:44 PM, licensed nursing staff K stated the direct care staff documented the bowel movements and the nurses should obtain orders from the physicians for as needed medications.</p> <p>During an interview on 05/10/2016 at 4:43 PM, licensed nursing staff N stated he/she was not</p>	F 329			

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F 329	Continued From page 52 aware if the resident was constipated.  During an interview on 05/11/2016 at 7:42 AM, licensed nursing staff M stated the nurses received a list of residents who had not had bowel movement for more than 3 days, which staff was to act upon. However, there was not a physician's standing order for medications to treat constipation.  During an interview on 05/11/2016 at 10:20 AM, administrative nursing staff D confirmed there was a system failure of monitoring for bowel movements.  The facility's Medication Management Guidelines policy dated 5/28/2002 documented the licensed nurse should implement the physician's instructions for monitoring, and report adverse drug reactions.  The facility failed to monitor the constipating side effects of medications for this resident.	F 329			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428			

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F 428	<p>Continued From page 53</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility identified a census of 94 residents. The sample was 18 residents, with 5 residents sampled for medication review. Based on observation, record review and interview, the facility's consultant pharmacist failed to identify and notify staff to monitor for the side effects of medications for residents #7, #85 and #118, and failed to identify and notify staff to monitor the effectiveness of medications for resident #118.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The physician's progress note for resident #118 dated 3/30/16 documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory, confusion).</li> </ul> <p>The Physician's Order Sheet for April 2016 noted orders for Depakote (a medication to stabilize the mood) 250 milligrams (mg) by mouth twice a day and Docusate sodium (a stool softener) 200 mg by mouth twice a day.</p> <p>The clinical record lacked orders for any as needed medications for constipation (difficulty passing a bowel movement).</p> <p>The Significant Change Minimum Data Set (MDS) dated 4/29/16 noted the resident had short term and long term memory problems with moderately impaired cognitive skills for decision making. He/she did not exhibit behavioral symptoms.</p> <p>The Care Area Assessments (CAAs) dated 4/29/16 documented the resident displayed confusion and disorientation to his/her</p>	F 428			

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F 428	<p>Continued From page 54</p> <p>surroundings. The resident cried out, "Help, help", but was unable to communicate a specific need.</p> <p>The care plan dated 4/1/16 noted staff allowed the resident time to make decisions, explained all procedures prior to starting, and provided cuing and prompting as needed. The target behavior was the resident called out, "Help me".</p> <p>Bowel movement records for April 2016 noted the resident did not have a bowel movement from 4/5/16 until 4/10/16 (5 days), from 4/10/16 until 4/15/16 (5 days), from 4/17/16 until 4/22/16 (5 days), and from 4/25/16 until 5/2/16 (7 days).</p> <p>Pharmacist medication reviews dated 4/1/16 and 5/1/16 failed to identify the lack of monitoring of the resident's bowel movements.</p> <p>According to the U.S. Food and Drug Administration, the side effects of Depakote included constipation.</p> <p>On 5/9/16 at 12:17 PM, the resident sat in a wheelchair in the hall. He/she waved and smiled at staff.</p> <p>On 5/10/16 at 5:54 PM, direct care staff V stated staff documented bowel movements when the resident had one, and the nurse received a list of residents every day who had not had a bowel movement within 3 days. Staff V said the nurses acted upon the list.</p> <p>On 5/10/16 at 5:06 PM, licensed nursing staff I stated stated the direct care staff charted when a resident had a bowel movement. The administrative nursing staff generated a list of residents who had not had a bowel movement in</p>	F 428			

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F 428	<p>Continued From page 55</p> <p>3 days from the Care Tracker (where the bowel movements were documented). He/he confirmed the list with the direct care staff, and then gave an as needed laxative per the physician's orders.</p> <p>On 5/11/16 at 10:20 AM, administrative nursing staff D confirmed there was a lack of monitoring of the resident's bowel movements and there was a system failure.</p> <p>The facility's policy "Bowel Management Interventions", dated 1/1/01, noted staff were to monitor medication use carefully.</p> <p>The facility's consultant pharmacist failed to identify and notify staff to monitor for medication side effects.</p> <p>Furthermore, the facility failed to monitor resident #118's target behaviors in March 2016.</p> <p>The Physician's Order Sheet for April 2016 noted orders for Depakote (a medication to stabilize the mood) 250 milligrams (mg) by mouth twice a day.</p> <p>The Significant Change Minimum Data Set (MDS) dated 4/29/16 noted the resident had short term and long term memory problems with moderately impaired cognitive skills for decision making. He/she did not exhibit behavioral symptoms.</p> <p>The Care Area Assessments (CAAs) dated 4/29/16 documented the resident displayed confusion and disorientation to his/her surroundings. The resident cried out, "Help, help", but was unable to communicate a specific need.</p> <p>The care plan dated 4/1/16 noted staff allowed</p>	F 428			

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F 428	<p>Continued From page 56</p> <p>the resident time to make decisions, explained all procedures prior to starting, and provided cuing and prompting as needed. The target behavior was the resident called out, "Help me".</p> <p>The clinical record lacked evidence of documentation of monitoring of targeted behaviors for March 2016.</p> <p>Pharmacist medication reviews dated 4/1/16 and 5/1/16 failed to identify the lack of monitoring of the resident's targeted behaviors.</p> <p>On 5/9/16 at 9:55 AM, the resident called out, "Help me, help me".</p> <p>On 05/09/2016 at 3:19 PM, licensed nursing staff M stated when a resident had behaviors, nursing staff charted them in the clinical record.</p> <p>On 05/09/2015 at 3:49 PM, direct care staff W stated when he/she saw behaviors, he/she reported them to the nurse and the nurse charted the behaviors.</p> <p>On 5/10/16 at 11:52 AM, administrative nursing staff G stated he/she expected staff to monitor the resident's behavior as the resident received Depakote. He/She confirmed there was a lack of behavior monitoring for March 2016 for the resident.</p> <p>On 5/10/16 at 5:06 PM, licensed nursing staff I stated the resident repeatedly asked questions and frequently yelled, "Help me". He/she said staff redirected the resident with the interventions on the behavior monitoring form in the resident's clinical record.</p>	F 428			

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F 428	<p>Continued From page 57</p> <p>On 5/10/16 at 5:54 PM, direct care staff V stated the resident frequently yelled, "Help me".</p> <p>The facility's policy "Medication Management Guidelines", dated 5/28/12, noted an adverse drug reaction was an undesirable effect of a drug which is different from the intended effect. The physician would be notified of an adverse drug reaction.</p> <p>The facility's policy "Psychopharmacological Medication", dated 10/30/01, revealed staff were to assess the resident's response to treatment and care.</p> <p>The facility's pharmacy consultant failed to identify and notify staff to monitor the targeted behaviors related to a medication's effectiveness.</p> <p>- The signed Physician's Order Sheet (POS) dated 4/25/2016 listed resident #7 had diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</p> <p>The admission Minimum Data Set (MDS) dated 3/30/16 revealed the resident had Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. The resident required extensive assistance with toileting use and personal hygiene. The resident received scheduled and as needed pain medications.</p> <p>The Care Area Assessment (CAA) dated 4/3/16 revealed the resident required extensive assistance with his/her transfers and toileting. The resident was alert and oriented, and he/she made her needs known.</p> <p>The care plan dated 4/5/16 revealed nursing staff</p>	F 428			

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F 428	<p>Continued From page 58</p> <p>documented when the resident had a bowel movement.</p> <p>Review of the signed physician order sheet dated 3/23/16 revealed the resident received morphine sulfate ER (extended release) (used for moderate to severe pain) 30 mg (milligrams) 1 tablet every 12 hours, and oxycodone IR (immediate release) (used for moderate to severe pain) 5 mg 2 tablets every 6 hours as needed.</p> <p>The U.S. Food and Drug Administration recommendations revealed the side effects of morphine and oxycodone included constipation.</p> <p>Review of Bowel Detailed Entry Report from March 2016 to May 2016 documented the resident had not had a bowel movement from 3/28/16 until 4/2/16 (5 days), from 4/7/16 until 4/11/16 (4 days), from 4/19/16 until 4/25/16 (6 days) and from 4/26/16 until 5/1/16 (5 days).</p> <p>Review of the Medication Administration Record from March to May 2016 noted the resident did not receive any order of as needed medications for constipation.</p> <p>Observation on 05/11/2016 at 7:44 AM, direct care staff Q and R transferred the resident to the toilet.</p> <p>On 05/09/2016 at 2:25 PM, the resident stated he/she was constipated, and needed staff's assistance with toileting.</p> <p>On 05/09/2015 at 3:49 PM, direct care staff W stated all direct care staff should chart bowel movements every shift.</p>	F 428			

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F 428	<p>Continued From page 59</p> <p>On 05/10/2016 at 10:07 AM, direct care staff R reported the resident had constipation.</p> <p>On 05/10/2016 at 1:44 PM, licensed nursing staff K stated the direct care staff documented the bowel movements and the nurses should obtain orders from the physicians for as needed medications.</p> <p>On 05/11/2016 at 7:42 AM, licensed nursing staff I stated the nurses received a list of residents who had not had a bowel movement for more than 3 days which staff was to act upon. However, there was not a physician's standing order for medications to treat constipation.</p> <p>On 05/11/2016 at 10:20 AM, administrative nursing staff D confirmed there was a system failure of monitoring for bowel movements.</p> <p>On 05/11/2016 at 3:18 PM, consultant pharmacist KK stated he/she checked the bowel monitoring records for completeness of documentation and he/she did not check the frequency of bowel movements.</p> <p>The facility's Medication Management Guidelines policy dated 5/28/2002 documented the licensed nurse should implement the physician's instructions for monitoring and report adverse drug reactions.</p> <p>The facility failed to monitor the constipating side effects of the medications for this resident.</p> <p>- The signed Physician's Order Sheet (POS) dated 4/20/2016 listed resident #85 had diagnoses of aphasia (condition with disordered or absent language function), cerebrovascular</p>	F 428			

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F 428	<p>Continued From page 60</p> <p>accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The signed physician's order dated 4/25/2016 revealed the resident received mirtazapine (used for depression) 12 milligrams (mg) 1 tablet daily.</p> <p>The annual Minimum Data Set (MDS) dated 11/19/15 revealed the resident had short and long term memory problems and severely impaired cognition. The resident required assistance with transfer and toileting. He/she was always incontinent with bowel movements.</p> <p>The quarterly MDS dated 2/11/16 revealed the resident had short and long term memory problems and severely impaired cognition. The resident required assistance with transfer and toileting. He/she was always incontinent with bowel movements.</p> <p>The Care Area Assessments (CAAs) dated 12/2/15 revealed the resident had diagnoses of cerebrovascular accident and depression. Staffs provided assistance with his/her Activities of Daily Living (ADLs) to prevent complications associated with incontinence, and monitor for adverse side effects of the antidepressant.</p> <p>The care plan dated 12/18/14 revealed the resident received antidepressants and the staff was to monitor the potential side effects of his/her antidepressant medication. The resident had cognitive impairment and staff was to provide assistance with transfer and toilet use.</p>	F 428			

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F 428	<p>Continued From page 61</p> <p>The U.S. Food and Drug Administration recommendations revealed the side effects of mirtazapine included constipation.</p> <p>Review of Bowel Detailed Entry Report from March to May 2016 documented the resident had not had a bowel movement from 3/23/16 until 3/28/16 (5 days), from 3/29/16 until 4/2/16 (4 days), from 4/4/16 until 4/10/16 (6 days), from 4/17/16 until 4/23/16 (6 days), and from 4/24/16 until 4/28/16 (4 days).</p> <p>Review of Medication Administration Record (MAR) from March 2016 to May 2016 noted the resident had received Milk of Magnesia 15 milliliters (ml) as needed once in the month of March (the staff was unable to determine the hand written date on the MAR).</p> <p>Observation on 05/09/2016 at 11:25 AM, the resident sat in his/her wheelchair and attended group exercise in the day room.</p> <p>On 05/09/2015 at 3:49 PM, direct care staff W stated all direct care staff should chart bowel movements every shift.</p> <p>On 05/10/2016 at 10:07 AM, direct care staff R confirmed the resident had constipation.</p> <p>On 05/10/2016 at 1:44 PM, licensed nursing staff K stated the direct care staff documented the bowel movements and the nurses should obtain orders from the physicians for as needed medications.</p> <p>On 05/10/2016 at 4:43 PM, licensed nursing staff N stated he/she was not aware if the resident was constipated.</p>	F 428			

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F 428	Continued From page 62  On 05/11/2016 at 7:42 AM, licensed nursing staff I stated the nurses received a list of residents who had not had bowel movement for more than 3 days, which staff was to act upon. However, there was not a physician's standing order for medications to treat constipation.  On 05/11/2016 at 10:20 AM, administrative nursing staff D confirmed there was a system failure of monitoring for bowel movements.  On 05/11/2016 at 3:18 PM, consultant pharmacist KK stated he/she checked the bowel monitoring records for completeness of documentation and he/she did not check the frequency of bowel movements.  The facility's Medication Management Guidelines policy dated 5/28/2002 documented the licensed nurse should implement the physician's instructions for monitoring, and report adverse drug reactions.  The facility failed to monitor the constipating side effects of the medications for this resident.	F 428			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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.	F 431			

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F 431	<p>Continued From page 63</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 94 residents. The facility included 3 medication rooms and 7 medication carts. Based on observation, record review, and interview, the facility failed to store medications properly in 1 medication room and 1 medication cart during survey.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Observation on 05/04/2016 at 9:29 AM of a medication cart revealed there was an open and undated Breo inhaler (used to treat airflow</li> </ul>	F 431			

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F 431	<p>Continued From page 64</p> <p>obstruction) and an open and undated Incruse Ellipta inhaler (oral inhalation medicine used to treat symptoms of chronic obstructive pulmonary disorder).</p> <p>Review of Breo inhaler and Incruse inhaler manufacturer instructions revealed Breo inhaler and Incruse inhaler should be dated when removed from the foil pouch and discarded 6 weeks after removal from foil pouch.</p> <p>Observation on 05/04/2016 at 9:55 AM, a medication room revealed the following open and undated injection pens: (all medications used to treat diabetes (A chronic condition that affects the way the body processes blood sugar)) one Victoza pen, two Levemir pens and one Symmlinpen. There was one Lantus pen dated 3/25/2016 (40 days prior to the observation).</p> <p>Review of Symmlinpen manufacturer instructions revealed an opened Symmlinpen should be dated upon opening and discarded after 30 days.</p> <p>Review of Levemir manufacturer instructions revealed an opened Levemir injection pen should be dated upon opening and discarded after 42 days.</p> <p>According to U.S. Food and Drug Administration recommendation, an opened Lantus pen should be discarded after 28 days.</p> <p>According to U.S. Food and Drug Administration recommendation, an opened Victoza pen should be discarded after 30 days.</p> <p>On 05/04/2016 at 9:35 AM, licensed nursing staff L stated the nurses dated all inhalers upon</p>	F 431			

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F 431	Continued From page 65 opening.  On 05/04/2016 at 10:02 AM, licensed nursing staff K advised he/she was not aware of the expired insulin pen. He/ She said the nurses were expected to date the insulin pens upon opening them.  On 05/04/2016 at 5:00 PM, administrative nursing staff D stated he/she expected the nurses to date all medications upon opening them.  The policies the facility provided did not include the medications mentioned above.  The facility failed to properly store resident medications, including inhalers and injectable medications used to treat diabetes.	F 431			
F 441 SS=E	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	F 441			

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F 441	<p>Continued From page 66</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 94 residents with 3 divided units. Based on observation, record review and staff interview, the facility failed to utilize precautions to minimize transmission of infection by failing to follow the manufacturer's recommendations for disinfecting resident rooms and failing to follow appropriate glove use while providing housekeeping services in resident rooms on 3 of 5 halls in the facility during survey.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Observation on 05/10/2016 at 10:51 AM revealed housekeeping staff X donned gloves before entering the resident's bathroom. He/she sprayed a bottled labelled "Diversity Virex 256 one-step disinfectant cleaner and deodorant" onto</li> </ul>	F 441			

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F 441	<p>Continued From page 67</p> <p>the sink in the bathroom, then immediately wiped the disinfectant off of the sink with a dry washcloth. Then he/she sprayed the same bottle on the surfaces of the toilet and wiped the same disinfectant off immediately.</p> <p>Observation on 05/10/2016 at 10:54 AM revealed housekeeping staff X poured a bottle labelled "Diversity Crew Heavy Duty Toilet Bowl Cleaner" inside the toilet bowl. He/she brushed the toilet bowl for approximately one minute, and then flushed the toilet. Staff X exited the bathroom without removing the gloves, and wiped off the bedside table and window counter surfaces in the resident's room. He/she did not change the contaminated gloves during this process.</p> <p>Review of the manufacturer instructions of "Diversity Virex 256 one-step disinfectant cleaner and deodorant" noted all surfaces must remain wet for 10 minutes to disinfect, then wipe surfaces and let air dry.</p> <p>Review of the manufacturer instructions of "Diversity Crew Heavy Duty Toilet Bowl Cleaner" noted staff should pour 1 ounce of toilet bowl cleaner on applicator and clean the entire unit, especially under the rim at the water outlets, and allow the cleaner to remain 10 minutes to disinfect before flushing.</p> <p>During an interview on 05/10/2016 at 10:57 AM, housekeeping staff X stated he/she was not aware of the contact time of the disinfectants he/she used in the resident's rooms. He/she confirmed they wore the same pair of gloves while cleaning the resident's bathroom and bedroom.</p>	F 441			

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F 441	<p>Continued From page 68</p> <p>During an interview on 05/10/2016 at 1:39 PM, housekeeping staff Y confirmed housekeeping staff had not left the disinfectants on the surfaces in the resident's rooms long enough to disinfect as the label instructed. Regarding use of gloves while providing housekeeping services, he/she stated the housekeeping staff were expected to follow the Standard Precautions policy.</p> <p>Review of facility's Standard Precaution policy revised 10/15/14 documented staff should remove gloves and wash hands before touching non-contaminated items and environmental surfaces.</p> <p>The facility failed to minimize transmission of infection by failing to follow the manufacturer's recommendations for disinfecting resident rooms and failing to follow appropriate glove use while providing housekeeping services in resident rooms on 3 of 5 halls in the facility.</p>	F 441			