STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	175044		07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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		
	The following citations represent the findings of a Health Resurvey and Complaint Investigation # 99271.			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		
	A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)			
	This REQUIREMENT is not met as evidenced by: The facility identified a census of 86 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to complete a significant change assessment when indicated for 1(resident #103) of 13 sampled residents.			
	Findings included:			
	- The quarterly Minimum Data Set (MDS) dated 2/1/16 for resident #103 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate cognitive			

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 274	Continued From page 1 impairment. The resident needed supervision with bed mobility, transfers, locomotion and toilet use. The resident used walker, and his/her gait was steady at all times. The resident was always continent (control of urine) of bladder. The resident received scheduled pain medication and denied pain. The resident had no falls since the prior assessment. The quarterly MDS dated 4/18/16 revealed the resident had a BIMS score of 12 which indicated moderate cognitive impairment. The resident required limited assistance with bed mobility, transfer, locomotion and toilet use. The resident used walker and wheelchair, and his/her gait was not steady. The resident was occasionally incontinent (involuntary leakage of urine) of bladder. The resident received both scheduled and as needed pain medication, and he/she reported pain of a 6 on the 0 -10 pain numeric scale. He/she had two falls since the prior assessment. The resident had significant changes in these areas from 2/1/16 to 4/18/16: increase in assistance with Activities of Daily Living (ADLs), worsening of his/her gait and balance, bladder continence, pain, and the occurrence of falls. The care plan dated 4/26/16 revealed the resident used a wheelchair for locomotion, and he/she demonstrated incontinence of bladder and bowel. The resident needed stand by assist with bed mobility, transfers, and toileting. The ADL charting from January 2016 to May 2016, recorded in January and February 2016 the resident was independent with all ADLs; in March, April and May 2016, the resident needed	F 274		

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F 274	Continued From page 2 assistance with ADLs. The physician's progress note, dated 3/25/16, noted the resident complained of pain in his/her knee and calf in the mornings, and he/she refused to walk at times. The Interdisciplinary Notes, dated 3/5/16 and 3/23/16, noted the staff found the resident on the floor in his/her room. The Interdisciplinary Notes dated 3/24/16, noted the resident needed staff assistance to get up in the morning, which was unusual for him/her. The resident required one person assist with transferring, and he/she also reported he/she needed a wheelchair for mobility. According to the Resident Assessment Instrument, a significant change reassessment is generally indicated when there is a decline or improvement consistently in 2 or more areas. On 07/14/2016 at 1:02 PM, the resident required direct care staff O's assistance to transfer from the wheelchair to the toilet. On 07/18/2016 at 10:10 AM, the resident required assistance from direct care staff O to transfer from the toilet to the wheelchair. On 07/18/2016 at 10:15 AM, the resident stated he/she used to walk around with a walker, but now he/she was too weak to walk and used a wheelchair. The resident added he/she needed help from staff with toileting. On 07/14/2016 at 1:05 PM, direct care staff O stated in January and February 2016, the resident	F 274		

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F 274	Continued From page 3 was able to ambulate by himself/herself with a walker, but the resident had declined in mobility since March or April 2016. On 07/14/2016 at 1:57 PM, licensed nursing staff L stated the resident had declined with mobility since the beginning of the year. On 07/18/2016 at 10:40 AM, administrative nursing staff G stated he/she disagreed that there was a decline in the resident's mobility between February 2016 and April 2016. On 07/18/2016 at 3:24 PM, administrative nursing staff G stated he/she did not think there was a need for a significant change MDS for the resident, because the resident did not require extensive assist. He/she said the resident's infrequent complaints of pain did not indicate the need for a significant change MDS assessment. Staff G also added the resident declined in only 2 areas of ADLs. On 07/19/2016 at 3:34 PM, administrative nursing staff D stated the resident had declined since February 2016 Staff D confirmed a significant change MDS assessment should have been done between February and April 2016. The facility's "Resident Assessment Policy", dated 10/30/2010, documented any significant changes in the resident's condition would require an immediate reassessment, with changes in the plan of care reflecting the change in condition. The facility failed to complete a significant change assessment when indicated for this cognitively impaired resident who experienced a decline.	F 274		

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F 309	Continued From page 4	F 309		
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 86 residents, with 13 residents sampled. Based on observation, record review and interview, the facility failed to ensure 1 resident (resident #103) maintained the highest physical, mental and psychosocial well-being by effectively managing the resident's pain. Findings included: - Resident # 103's signed Physician Order Sheet (POS) dated 7/11/16, included diagnoses of idiopathic peripheral neuropathy (a damage to the peripheral nerves, often causes weakness, numbness and pain), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), osteoarthrosis (chronic arthritis without inflammation), pain in joint, and disorder of bone and cartilage. The POS also included the resident received Tylenol (a pain medication for minimal to moderate pain) 325 milligram (mg), 1 tablet 4 times a day, and staff pain assessment every 12 hour. The annual Minimum Data Set (MDS) dated	F 309		

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F 309	Continued From page 5 8/31/15 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated a moderatly impaired cognition. The resident needed supervision with walking, transferring and locomotion. He/she used a walker and his/her gait was steady at all times. The resident did not receive pain medication and denied having pain. The resident did not have a fall prior to the assessment. The quarterly MDS dated 4/18/16 revealed the resident had a BIMS score of 12, which indicated a moderate impaired cognition. The resident required assistance with walking, transferring and locomotion, and the locomotion off the unit only occurred 1-2 times in a week. He/she used a walker and a wheelchair, and his/her gait was unsteady. The resident received both scheduled and as needed pain medication and reported pain of 6 on a 0 to 10 numeric pain scale. The resident had 2 falls prior to the assessment. The Care Area Assessment dated 8/31/15 for cognitive loss revealed the resident had moderately impaired cognition. For Activities of Daily Living (ADLs), the staff monitored medication for effectiveness and adverse reactions; for the fall, resident enjoyed walking and walked around in the unit several times a day; the CAA for pain did not trigger. The temporary care plan dated 7/11/16 noted the resident required one person assist with toileting, and 2 person assist with transfers to the wheelchair for mobility. The care plan dated 4/26/16 noted staff monitored the resident's pain level every shift and the effectiveness of any pain medication. The	F 309		

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F 309	Continued From page 6 resident received Lasix (a medication to get rid of excessive fluids in the body) for lower extremity edema (swelling). The Medication Administration Record (MAR), from March 2016 to July 18, 2016, documented the scheduled Tylenol was not administered. Review of the MAR revealed Tylenol was administered as needed 8 times in March, 9 times in April, 8 times in May, 3 times in June, and once from 7/11/16 to 7/18/16. The MAR noted the noon doses of Tylenol were held due to the morning dose given at noon. The MAR, from March 2016 to July 18, 2016, documented the following pain based on the 0 to 10 scale: in March 2016, the resident reported pain 6 times and rated 4 to 7; in April 2016, the resident reported pain 5 times and rated 4 to 6; in May 2016, the resident reported pain 6 times and rated pain 3 to 10; from 7/11/16 to 7/18/16, the resident reported pain on 7/17/16 and rated the pain 4. The MAR, from March 2016 to July 18 2016, documented as needed Tylenol 325mg 2 tabs were given once in March, 2 times in May. The physician progress note dated 3/25/16, noted the resident complained of pain in his/her knee and calf in the mornings. The resident had refused to walk on it at times. The physician progress note dated 5/2/16, noted the resident reported edema and pain on his/her legs. The physician progress note dated 5/18/16, noted the resident continued to have edema on both	F 309		

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F 309	Continued From page 7 lower extremities, the right leg was worse than the left. The nursing assessment dated 7/11/16 addressed the resident reported occasional pain and rated 5 on 0 to 10 pain scale. The Interdisciplinary note dated 3/1/16, revealed the resident with a slight limp when ambulating, and he/she reported pain in the knee. The Interdisciplinary note dated 3/27/16, revealed the resident reported pain in the right leg and the right knee. The Interdisciplinary note dated 4/21/16, revealed the resident reported his/her right knee hurt more than usual. The Interdisciplinary note dated 5/12/16, revealed the resident reported right lower leg pain. The Interdisciplinary note dated 7/18/16, revealed the resident had edema of the left foot and also complained left foot pain. The resident had an order for scheduled Tylenol. On 07/18/2016 at 10:28 AM, observation included moderate pitting edema on both of the resident's lower legs. On 07/18/2016 at 3:07 PM, the resident propelled himself/herself in the wheelchair. On 07/19/2016 at 1:35 PM, the resident stated he/she had left foot pain, rated 3 on the 0 to 10 scale. On 07/18/2016 at 10:28 AM, the resident stated	F 309		

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F 309	Continued From page 8 he/she had pain at times. On 07/18/2016 at 10:33 AM, the resident stated he/she felt helpless but not depressed because he/she could not walk as he/she used to. On 07/19/2016 at 9:42 AM, the resident reported pain of the left calf, and he/she also stated the pain bothered him/her especially when ambulating. On 07/19/2016 at 9:44 AM, direct care staff S stated the resident had complained about pain in the legs and knees 1 to 2 times a week, and he/she would report to the nurse. Staff S also stated the resident had refused to walk due to the pain. On 07/14/2016 at 1:57 PM, licensed nursing staff L stated the resident started to have leg and feet swelling and pain few months ago, which might have affected the resident's mobility. On 07/19/2016 at 9:18 AM, licensed nursing staff L stated the resident reported pain once a week, the pain was usually in legs, ankles and feet, and the resident received Tylenol 325 mg, 1 tablet, 4 times a day. Staff L added the resident did not have an order for as needed Tylenol since he/she admitted back from the hospital on 7/11/16. On 07/19/2016 at 9:47 AM, administrative nursing staff GG stated he/she was aware of the resident's edema and pain in the lower extremities in April, May and June and he/she did not know if the pain problem was resolved or not. Staff GG also added he/she thought the as needed Tylenol was not given was because the scheduled Tylenol time frame was close and	F 309		

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F 309	Continued From page 9 he/she was not aware if the scheduled Tylenol 325mg, 1 tablet, 4 times a day was effective or not. On 07/19/2016 at 9:57 AM, administrative nursing staff G stated he/she did not think complaining of pain 5 to 6 times in one month was severe. On 07/19/2016 at 3:42 PM, administrative nursing staff D stated according to resident's MAR and clinical documents, his/her pain was well managed. On 07/19/2016 at 1:58 PM, nurse practitioner JJ stated he/she was aware the resident experienced leg swelling and leg pain, and he/she would look into the resident's pain medication review. The facility's Management of Elder Pain Policy dated 6/10/2010, documented it was the responsibility of all clinical staff to assess and periodically reassessed the resident for pain and relief from pain. The facility failed to monitor and evaluate the effectiveness of the pain management for this cognitively impaired resident who experienced pain frequently.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		

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F 311	Continued From page 10 by: The facility identified a census of 86 residents. The sample included 13 residents. Based on observation, record review and interviews, the facility failed to ensure that one (#84) of four residents of the sample reviewed for Activities of Daily Living (ADL's) with a significant weight loss over a 6 month period, received encouragement and assistance with meals as stated in the care plan. Findings included: - Resident #84's diagnoses from the Physician's Order Sheet dated 7/6/16 included: Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), transient cerebral ischemia (episode of cerebrovascular insufficiency), osteoarthrosis (chronic arthritis without inflammation), dementia (progressive mental disorder characterized by failing memory, confusion) with lewy bodies (protein deposits in the brain involved with thinking, memory and movement). The admission Minimum Data Set (MDS) dated 9/21/15 revealed a Brief Interview for Mental Status (BIMS) score of 11 (indicating moderately impaired cognition). The quarterly MDS dated 5/16/16 revealed a BIMS score of 9 (indicating moderately impaired cognition). The resident required supervision and set up assistance with eating. The care plan dated 5/24/16 identified the resident at risk for altered nutritional status	F 311		

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F 311	Continued From page 11 related to the diagnosis of Parkinson's. The resident ate a regular diet. Staff were directed to offer the resident preferences/substitutes as needed and monitor and record the resident's intake. Staff were to encourage at least 75% consumption of meals and snacks for adequate caloric intake. The resident ate independently. The care plan revision dated 7/13/16 directed staff to offer the resident enhanced foods. Review of the resident's weights over 180 days from the clinical record revealed a significant weight loss of 12.39%. The 5/20/16 Nutritional status quarterly review entered by dietary staff FF stated the resident continued to feed himself/herself a regular diet with no chewing or swallowing problems. On 07/14/2016 at 11:54 AM included the resident sat in his/her wheelchair (w/c), at a dinner table. At 12:01 PM staff served the resident the noon meal of a sandwich, sun chips (a type of chip snack) and water. The staff asked if they could bring him/her anything else, he/she replied this was fine. His/her wheelchair was positioned 1-2 feet from the table, which caused the resident to reach back and forth across this distance to reach his/her plate. Staff did not offer to push her/him up to the table. Staff did not offer assistance opening the bag of chips, which took him/her approximately 5 minutes to open. At 12:30 PM staff assisted the resident out of the dining area. The resident consumed 75% of the meal. Observation on 07/18/2016 at 7:34 AM included the resident sat in his/her w/c at the breakfast	F 311		

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F 311	Continued From page 12 table. A dietary staff pushed him/her close to the table, and asked if he/she would like to fill out a menu. The staff explained the choices to him/her. The staff served the resident eggs and a bowl of oatmeal. The staff then poured milk on the oatmeal. At 7:45 AM the resident picked at the food, and ate very slowly. At 8:05 AM, he/she continued to pick at the food. Staff did not offer encouragement or assistance. At 8:16 AM the resident did not eat anything for 10 minutes, and was distracted with other activities. At 8:28 AM, nearly an hour after being served his/her food, the resident continued to sit at the table, not eating, and received no encouragement from staff. At 8:35 AM staff assisted the resident back to his/her room in the wheelchair. The resident consumed 5-10% of the meal, without encouragement from the staff. During an interview on 07/18/2016 at 2:02 PM direct care staff P stated his/her duties included taking the resident to the dining room. He/she stated the resident ate independently, and staff just watched the resident. Staff was able to look at the care plan, and had not noticed any decline in appetite or eating ability. Staff P report to the charge nurse any resident concerns. If there was a change in the resident's care plan the charge nurse will tell the direct care staff. The nursing staff had not mentioned the resident's weight loss to direct care staff P. On 07/18/2016 at 3:49 PM direct care staff Q stated if the resident was hungry, he/she ate. The resident was kind of mentally going downhill. The resident usually ate in the dining room, did not require help, and ate cookies for snacks. Staff Q was not aware if the resident received a protein shake.	F 311		

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F 311	Continued From page 13 On 07/19/16 at 1:29 PM licensed staff K stated the dietician received the printed weekly report, regarding the resident's 12.39% weight loss of 7/12/16. The policy dated 7/2/2010 for assisting elders with unintended weight loss stated: Elders will be promptly identified when they experience a weight loss and a plan that reflects the elders preferences will be developed to prevent further unintended weight loss. The policy dated 8/17/11 for nutritional documentation documented each elder will be assessed for nutritional needs at move in and periodically during their residency. The facility failed to provide this resident with encouragement and assistance at mealtimes which contributed to significant weight loss.	F 311		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		

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	175044		07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREWSTER HEALTH CENTER	1001 SW 29TH ST TOPEKA, KS 66611

(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 325	Continued From page 14 by: The facility identified a census of 86 with 13 residents sampled. Based on observation, record review, and interview, the facility failed to implement timely interventions to avoid significant weight loss of 12.39% or 17.2 pounds in 180 days for 1 (#84) of 3 residents sampled for nutrition. Findings included: - The Physician's order sheet dated 7/6/16 for resident #84 documented diagnoses of Parkinson's (a slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and dementia with Lewy bodies (progressive mental disorder characterized by failing memory, confusion). The Admission Minimum Data Set (MDS) dated 9/21/15 noted the resident with a BIMS (Brief Interview for Mental Status) score of 11, which indicated moderately impaired cognition. The resident weighed 139 pounds (lbs). The assessment identified no weight loss more than 5% in the prior month or 10% in the prior 6 months. The resident ate independently and had no dental, swallowing or skin issues. The Quarterly MDS dated 2/22/16 noted the resident with a BIMS (Brief Interview for Mental Status) score of 11, which indicated moderately impaired cognition. The resident ate independently but required set up help. The dental or nutrition areas did not trigger. The Quarterly MDS dated 5/16/16 noted the resident with a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderately	F 325		

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F 325	Continued From page 15 impaired cognition. The resident required cueing with meals and set up help. The dental or nutrition areas did not trigger. The care plan for nutrition dated 2/29/16 noted the resident began to take medication to increase appetite and included the resident's favorite foods. This included egg sandwiches, jello, applesauce, toast, pancakes, and chicken nuggets dipped in white gravy. The resident's favorite snacks included sweets such as cookies, kettle corn and milk shakes. The nutrition care plan dated 5/24/16 documented the resident consumed a regular diet and ate independently. Staff were directed to offer the resident food preferences and substitutes as needed, monitor and document the resident's meal intake. The resident was identified at risk for altered nutritional status related to the diagnosis of Parkinson's. The care plan directed staff to encourage the resident with at least 75% consumption of meals and snacks for adequate caloric intake. The admission nutritional risk assessment dated 9/23/15 documented a weight of 135.8 pounds, a loss of 2.3% in 1 month, and the resident meal consumption at 65% which put the resident at moderate risk. The quarterly nutritional risk assessment dated 12/5/15 documented a weight of 137.2 pounds, a loss of 0.29%, or 5.6 pounds in 3 months. The resident's overall meal consumption documented at 63%. The quarterly nutritional risk assessment dated 2/15/16 documented a loss of 4 lbs., or	F 325		

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F 325	Continued From page 16 approximately 3% weight loss in 1 month. The quarterly nutritional risk assessment dated 5/18/16 documented a weight of 128.6 pounds, a loss of 4.74% in 3 months The clinical record revealed the resident's weights over 180 days as follows: 1/12/16 138.8 pounds 2/12/16 131.8 pounds 4/12/16 129.2 pounds 5/10/16 129.4 pounds 6/14/16 127 pounds 6/21/16 126.4 pounds 6/28/16 124.4 pounds 7/5/16 124.4 pounds 7/12/16 121.6 pounds This is a loss of 17.2 pounds, a 12.39% in 6 months. The nutritional status quarterly review dated 5/20/16 included the resident continued to feed himself/herself a regular diet with no chewing or swallowing problems. The average meal intake was 63%, snacks 11%, and fluids 1096 cubic centimeters (cc) daily. The estimated nutritional needs of the resident were 1339 calories, 58 grams of protein, and 1740 cc of fluid. The resident's current weight was 128.6 pounds, a loss of 4.74% in 3 months. The resident's BMI (body mass Index) was 21.3 which wass below the desired level. The physician's order dated 2/29/16 documented the resident to be administered Remeron, (an antidepressant also used as an appetite stimulant) 15 milligram (mg) tablet, give 7.5	F 325		

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F 325	Continued From page 17 milligrams (mg) by mouth (po) daily (qd) for depression, decreased appetite and not feeling well in general. The Nurse's note dated 7/13/16 stated the Physician and his/her Advanced Registered Nurse Practitioner (ARNP) saw the resident, reviewed the resident's weight loss and ordered Remeron 7.5 mg, po, qd for appetite. Staff called the physician to clarify the order received from the ARNP as the resident was already taking that dose of the medication. There were no new orders. Review of the resident's meal percentage charting revealed the following: April 2016 - 17/90 meals 0-25% of meal consumed, 3 meals not charted, 16/19 meals 50% consumed, 34/90 meals 75% consumed. May 2016 - 16/93 meals 0-25% consumed, 1 meal not charted, 19/93 meals 50% consumed, 31/93 meals 75% consumed. June 2016 - 12/90 meals 0-25% of meal consumed, 7 meals not charted on, 16/90 meals 50% consumed, 27/90 meals 75% consumed. July 2016 - 8/53 meals 0-25% of meal consumed, 3 meals not charted, 16/53 meals 50% consumed, 11/53 75% of meal consumed. The clinical record lacked evidence the facility reassessed the resident's weight loss, and implemented timely and effective interventions to prevent further weight loss. Observation on 07/14/2016 at 11:54 AM included the resident sat in his/her wheelchair (w/c), at a dinner table. At 12:01 PM staff served the resident the noon meal of a sandwich, sun chips (a type of chip snack) and water . The staff asked	F 325		

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F 325	Continued From page 18 if they could bring him/her anything else, he/she replied this was fine. His/her wheelchair was positioned 1-2 feet from the table, which caused the resident to reach back and forth across this distance to reach his/her plate. Staff did not offer to push her/him up to the table. Staff did not offer assistance opening the bag of chips, which took him/her approximately 5 minutes to open. At 12:30 PM staff assisted the resident out of the dining area. The resident consumed 75% of the meal. Observation on 07/18/2016 at 7:34 AM included the resident sat in his/her w/c at the breakfast table. A dietary staff pushed him/her close to the table, and asked if he/she would like to fill out a menu. The staff explained the choices to him/her. The staff served the resident eggs and a bowl of oatmeal. The staff then poured milk on the oatmeal. At 7:45 AM the resident picked at the food, and ate very slowly. At 8:05 AM, he/she continued to pick at the food. Staff did not offer encouragement or assistance. At 8:16 AM the resident did not eat anything for 10 minutes, and was distracted with other activities. At 8:28 AM the resident continued to sit at the table, not eating, and received no encouragement from staff. At 8:35 AM, nearly an hour after being served, staff assisted the resident back to his/her room in the wheelchair. The resident consumed 5-10% of the meal, without encouragement from the staff. During an interview on 07/18/2016 at 2:02 PM direct care staff P stated his/her duties included taking the resident to the dining room. He/she stated the resident ate independently, and staff just watched the resident. Staff was able to look at the care plan, and had not noticed any decline	F 325		

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F 325	Continued From page 19 in appetite or eating ability. Staff P report to the charge nurse any resident concerns. If there was a change in the resident's care plan the charge nurse will tell the direct care staff. The nursing staff had not mentioned the resident's weight loss to direct care staff P. On 07/18/2016 at 3:49 PM direct care staff Q stated if the resident was hungry, he/she ate. The resident was kind of mentally going downhill. The resident usually ate in the dining room, did not require help, and ate cookies for snacks. Staff Q was not aware if the resident received a protein shake. On 7/18/16 at 1:50 PM licensed staff K, stated if there was a weight loss the nurse on duty notified the doctor and charted in the ID (interdisciplinary) notes. Staff could offer shakes bid (twice a day) without a doctor's order and it should be charted what is offered in the Point of Care record (where the direct care staff document). Staff K confirmed the resident had declined in cognition. On 07/19/16 at 1:29 PM licensed staff K stated the dietician received the printed weekly report, regarding the resident's 12.39% weight loss of 7/12/16. On 7/18/16 at 1:40 PM dietary staff FF, stated if a resident lost enough weight he/she would be on a supplement, which would be 5% in 30 days. This should be charted in the weight tracker. On 07/19/16 at 10:45 AM registered dietary staff DD, stated he/she normally received an email from nurses if a resident had weight loss. He/she further stated today was the first day he/she was aware of the resident's significant	F 325		

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F 325	Continued From page 20 weight loss. Staff DD did not get an email last week regarding the resident's weight loss. Staff DD stated the nurses decide on weight loss interventions and talk with staff DD about them. Staff DD was not aware of what kind of snacks the resident received. Staff DD expected nursing staff to order protein shakes if a resident had weight loss. On 07/19/16 at 2:46 PM administrative nursing staff D and E stated the resident was not triggered for weight loss until last week so they were not looking at the resident's weight loss. Staff D stated they do need to look at to look at the facilities weight loss policy and look at certain percentages, and the need to look at the process of how soon weight loss triggered. Staff D acknowledged that the staff had a week to respond to a significant weight loss according to policy. On 7/20/16 at 3:00 PM physician staff KK stated he/she had been aware of the resident's gradual weight loss since February 2016, but it was not triggered as a concern as it did not meet the facility's criteria for weight loss until last week. He/she was aware that he/she had ordered Remeron in February when the resident began to have problems with eating. When physician KK was notified on 7/13/16 he/she did not increase the Remeron or change the medication as he/she believed if the remeron didn't help, nothing would. Physician staff KK stated that lab tests were performed in March and April when the resident had digestive problems and was started on Carafate (a medication used to treat gastroesophageal reflux disease and ulcers) 1 gram orally every day. Physician staff KK further stated that he/she would expect nursing staff to	F 325		

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F 325	Continued From page 21 notice the downward trend in the resident's weight even though it did not trigger for the facility and that they would notify him/her and put in place interventions such as protein shakes and encourage increased nutritional intake. The policy dated 7/2/2010 for assisting elders with unintended weight loss stated: Elders will be promptly identified when they experience a weight loss and a plan that reflects the elders preferences will be developed to prevent further unintended weight loss. The policy dated 8/17/11 for nutritional documentation documented each elder will be assessed for nutritional needs at move in and periodically during their residency. The facility failed to identify this residents avoidable significant weight loss of 12.39 in 180 days, and failed to implement timely interventions to prevent further weight loss.	F 325		
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	F 329		

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F 329	Continued From page 22 given these drugs unless antipsychotic drug 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. This REQUIREMENT is not met as evidenced by: The facility identified a census of 86 residents. The sample included 13 residents, 5 of which were reviewed for medications. Based on record review and staff interview, the facility failed to monitor the effectiveness of medications and notify the physician as ordered for 1 (#137) of 5 sampled when the resident's blood pressure exceeded the identified parameters. Findings included: - Review of the signed physician's order sheet (POS) dated 1/4/16 for resident #137, listed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and hypertension (high blood pressure). The Admission (14 day) Minimum Data Set (MDS) dated 1/10/16 documented a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderately impaired cognition. The Significant change MDS dated 5/20/16	F 329		

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F 329	Continued From page 23 documented a BIMS score of 9, indicating moderately impaired cognition. The care plan revised 6/2/16 documented the resident received pharmacological interventions for multiple diagnoses, with possible side effects from medications and directed staff to refer to the medication management care plan for administration instructions and potential side effects. The signed physician's orders dated 1/4/16 directed staff to call the physician if the resident's systolic blood pressure (top number of a blood pressure reading and the amount of pressure in the arteries during a contraction of the heart muscle) was more than 180 or less than 90 or if the diastolic blood pressure (the bottom number of a blood pressure reading and the amount of pressure when the heart is between beats) was greater than 100. The physician's order, dated 1/4/16, included the following: Carvedilol (given to regulate heart rate and decrease blood pressure) administer 6.25 milligram (mg) one tablet twice a day for hypertension, monitor heart rate, blood pressure, orthostatic blood pressure (sitting and standing blood pressure) and weight gain. Amlodipine (given to lower blood pressure) administer 10 mg orally every day for hypertension, monitor blood pressure, cardiac rhythm, pain and weight. The physician's order, dated 3/23/16, included Hydralazine (given to lower blood pressure) administer 25 mg tablet orally three times a day, monitor pulse, blood pressure and pain.	F 329		

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F 329	Continued From page 24 The nurse's note dated 6/30/16 at 1:45 PM documented a blood pressure of 184/88, which exceeded the recommendation from the physician. The record lacked documentation of notification to the physician, as ordered. The nurse's note dated 7/13/16 at 9:45 AM documented a blood pressure of 182/89, which exceeded the recommendation from the physician. The record lacked documentation of notification to the physician, as ordered. On 7/18/16 at 3:31 PM direct care staff R stated he/she took the resident's blood pressures and also administered medications. Staff R was not aware of the resident's blood pressure parameters. Staff R stated the blood pressure should show on the computer screen and staff R would then report it to the nurse. On 7/18/16 at 3:45PM, licensed nursing staff L stated he/she was not familiar with parameters for the resident's blood pressure. Licensed nursing staff L reviewed the resident's documented blood pressures and physician's orders and confirmed there was no documentation of the physician being notified on the days the resident's blood pressures exceeded the physician's ordered parameters. Licensed nursing staff L also verified that the correct parameters were on the resident's care plan which stated to notify the physician if the resident's systolic reading was greater than 180 or less than 90. On 7/19/16 at 2:52 PM administrative nursing staff D stated he/she expected that if a doctor gave parameters and the resident's blood	F 329		

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F 329	Continued From page 25 pressure was out of those parameters, the nurse taking the blood pressure was responsible for notifying the doctor. A Certified Medication Aide would be responsible for notifying the nurse. The facility provided policy for assessing an elder's blood pressure, dated 2005, documented the licensed nurse will report to the elder's physician when systolic pressure is greater than 200 or less than 90, or diastolic pressure is greater than 110 unless the physician has set specific parameters for this elder. The facility failed to monitor the resident's medication related to high blood pressure, with physician orders which directed staff to notify the physician when the resident's blood pressure exceeded the identified parameters.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 26 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility identified a census of 86 residents. Based on observation, record review, and staff interview, the facility failed to utilize standard precautions to minimize transmission of infection for 8 residents when shared care equipment was not disinfected per manufacturer's directions. The facility failed to follow instructions for disinfection for contact time per labeled instructions of cleaning chemicals, and failed to change gloves after touching contaminated articles, to minimize the transmission of infection on 1 of 4 units. Findings included: - Observation on 7/13/16 at 3:43 PM revealed Licensed Nursing Staff H used an alcohol wipe to	F 441		

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F 441	Continued From page 27 clean the Evencare G2 glucometer (instrument used to calculate blood glucose) after checking Resident #132's blood sugar. Observation on 7/13/16 at 3:53 PM revealed Licensed Nursing Staff I used an alcohol wipe to clean the Evencare G2 glucometer after checking Resident #80's blood sugar. Review of Evencare G2 manufacturer's directions stated the glucometer used for multiple residents was to be cleansed with disinfectant wipes containing bleach. Interview on 7/13/16 at 4:15 PM with Licensed Nursing Staff H confirmed he/she used alcohol wipes to clean the glucometer in between residents. On 7/19/16 at 2:20 PM, Administrative Nurse D and Administrative Nurse E acknowledged they had not been following the recommended manufacturer 's directions for cleaning the glucometer. The 2/10/16 facility's Blood Glucose Monitoring policy indicated to cleanse the glucometer with a disinfectant wipe. Observation on 7/19/16 at 1:02PM revealed Direct Care Staff O used ProLink 9.5% Clinging Bowl Cleaner under the rim of the toilet bowl, and flushed the toilet 1 minute after applying. Staff O stated this was for a deep clean of Resident #103's toilet bowl. Review of manufacturer's instructions on the cleaner indicated it should be left in the bowl for a 10 minute contact time for deep cleaning.	F 441		

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	175044		07/22/2016

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F 441	Continued From page 28 Interview on 7/19/16 at 11:23 AM with Housekeeping Director X, stated he/she trained the lead kaizen (universal worker) on each unit on procedures for regular and deep-cleaning resident's rooms. The lead kaizen then trained the direct care staff on the units. Interview on 7/19/16 at 1:05 PM with Direct Care Staff O verified he/she was deep cleaning the bathroom. He/she was unsure if there was a wait time on the toilet bowl cleaner. Direct Care Staff O verified after checking instructions, it indicated the cleaner should be left in the bowl for 10 minutes for deep cleaning. On 7/19/16 at 2:20 PM Administrative Nurse D and Administrative Nurse E verified the toilet bowl disinfectant should have been left for 10 minutes. The 8/25/15 facility's Deep Cleaning an Elder's Bedroom policy indicated the resident's bedroom was to be thoroughly cleaned after move out and at least every six months. The policy further stated to clean the bathroom following the 8/25/15 Cleaning the Elder's Bathroom policy. Both policies lacked in the procedure section to follow the manufacturer's instructions for wait times and/or identify the expected wait time for deep cleaning. Observation on 7/19/16 at 9:49 AM revealed Direct Care Staff O, cleaned resident #8's room. This same staff, did not change gloves after stripping dirty linens from the resident's bed. Staff O then touched his/her lanyard (a cord worn around the neck for carrying something) with his/her keys attached, after the lanyard dragged on the floor, removed the lanyard from around	F 441		

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F 441	Continued From page 29 his/her neck and placed it on the resident's bedside table, while continuing to wear the soiled gloves. Staff O then touched the resident's belongings wearing the same glove's that were used while cleaning the soiled bed linens. On 7/19/16 at 10:35 AM Direct Care Staff O acknowledged he/she did not change his/her gloves after removing soiled linen and cleaning the bed before touching the resident's personal belongings, and handling his/her lanyard with contaminated gloves. Staff O stated he/she should have changed the gloves. On 7/19/16 at 2:20 PM Administrative Nurse D and Administrative Nurse E verified staff should change gloves between touching contaminated and clean articles. The policy for Deep Cleaning an Elder's Bedroom, dated 8/25/15, indicated gloves to be used as needed. The facility failed to minimize the transmission of infection when staff failed to clean resident care equipment following manufacturer's directions between resident uses, failed to follow manufacturer's instructions for chemical set time to deep clean resident rooms, and failed to change gloves after touching contaminated articles.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	Continued From page 30 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: The facility reported a census of 86 residents. The sample included 13 residents of which 13 were reviewed for current physician's orders. Based on record review and interview the facility failed to obtain current and signed physician's orders for 2 of the 13 sampled residents (#89 and #118). Findings included: - Review of the medical record revealed resident #89's most recent signed physician orders were dated 12/2/15. On 7/19/16 at 10:42 AM, Medical Records Staff F confirmed the signed physician orders dated 12/2/15 were the most current. Staff F further stated the facility was to obtain signed physician orders every 60 days on every resident. He/she was aware there was a problem regarding timliness of the current physician's orders. On 7/19/16 at 11:07 AM, Administrative Nurse D and Administrative Nurse E stated the facility sent physician's orders every 60 days for the physician to sign. Both administrative nursing staff D and E	F 514		

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F 514	Continued From page 31 stated they were unaware that physician's orders were not current. The facility's Physician Orders for Medications and Treatments policy, dated 8/23/15, indicated the resident's physician reviewed and signed the physician orders every 60 days. The facility failed to obtain current and signed physician orders for Resident #89 since 12/2/15, which put the resident at risk for possible medication error(s). - Review of the medical record revealed resident #118's most recent signed physician order was dated 1/20/16. On 07/19/2016 at 8:54 AM, Medical Record Staff F stated the signed physician's order dated 1/20/16 was the most current. Staff F further stated the facility was to obtain signed physician orders every 60 days on every resident. He/she was aware there was a problem regarding timliness of the current physician's orders. On 7/19/16 at 11:07 AM, Administrative Nurse D and Administrative Nurse E stated the facility sent physician's orders every 60 days for the physician to sign. Both administrative nursing staff D and E stated they were unaware that physician's orders were not current. The facility's Physician Orders for Medications and Treatments policy, dated 8/23/15, indicated the resident's physician reviewed and signed the physician orders every 60 days. The facility failed to obtain current and signed physician orders for Resident #118 since 1/20/16, which put the resident at risk for possible medication error(s).	F 514		

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