

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

Printed: 09/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2015
NAME OF PROVIDER OR SUPPLIER CITIZENS MEDICAL CENTER LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 1625 S FRANKLIN AVE COLBY, KS 67701		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 48 residents. The</p>	F 157		
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 157	<p>Continued From page 1</p> <p>sample included 14 residents. Based on observation, record review and interview, the facility failed to notify the responsible party of a resident to resident altercation for 1 sampled resident. (#11)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #11's (MDS) Minimum Data Set assessment, dated 7/12/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident was independent with eating, ambulation, bed mobility, transfers, and required limited assistance of 1 staff member for toileting and dressing. The assessment further stated the resident had no behaviors, including rejection of care, or wandering. <p>The 7/21/15 care plan indicated the resident was independent with ambulation but required cues and direction, and instructed staff to complete 15 minute visual checks.</p> <p>The 8/25/15 at 2:30 PM, nurse's note stated the resident was seated at a dining room table when another resident punched him/her in the stomach. The note further stated the 2 residents were separated and he/she had no further altercations. The note stated the staff assessed the resident and had no injury or complaint of pain. Review of the medical record lacked any further documentation of the altercation or of a follow up assessment.</p> <p>The 8/25/15 facility Risk Management Investigation stated Resident #11 went to sit down at a table with another couple. The report</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>stated Resident #47 told Resident #11 to go sit elsewhere and when the resident did not leave, Resident #47 hit the resident in the stomach. The investigation indicated staff assessed Resident #11 and he/she had no redness or injury. The report stated both residents involved were interviewed and neither resident could recall the altercation. Resident #47's spouse stated they liked to be alone, and Resident #11 was not hit very hard. The report stated the staff were again educated about having only 2 chairs at the table and to allow the couple to have alone time.</p> <p>Review of the medical record and the investigation revealed Resident #11's responsible party was not notified of the incident.</p> <p>On 9/17/15 at 11:45 AM, observation revealed Resident #11 at the dining room table eating lunch. Further observation revealed Resident #47, and his/her spouse at another table, with an additional empty chair at the table. (observed 3 of 4 onsite days in the facility)</p> <p>On 9/16/15 at 7:55 AM, Nurse Aide P stated the staff assisted Resident #11 at meal times with cueing and direction. Nurse Aide P further stated he/she did not know of a resident to resident altercation involving Resident #11 and did not know only 2 chairs were to be placed at Resident #47's table.</p> <p>On 9/16/15 at 4:00 PM, Administrative Staff A stated the risk management department determines which incidents are called into the state agency.</p> <p>On 9/16/15 at 4:54 PM, Social Service Staff Q stated Resident #11 sat down at the table with a couple that liked to eat alone and when Resident</p>	F 157			

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F 157	Continued From page 3 #11 didn't leave, Resident #47 hit Resident #11. Social Service Staff Q stated he/she reviewed the camera and Resident #47 did not punch the resident in the stomach as documented by staff, but he/she just lightly hit at the resident, so the incident was not reported. Social Service Staff Q further stated the staff had been educated twice to keep only 2 chairs at the couples table so they can eat alone. On 9/17/15 at 10:30 AM, Licensed Nurse D stated the staff sit with Resident #11 during meals and assisted him/her as needed. Licensed Nurse D further stated he/she did not know of a resident to resident altercation involving Resident #11. The 5/14/15 facility's Admission Policy stated the facility would contact the responsible party or an family member when an emergency or change of condition occurs. The facility failed to notify Resident #11's responsible party that he/she had been involved in a altercation and had been hit by another resident.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225			

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F 225	<p>Continued From page 4 or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to thoroughly investigate and report a fall with injury to a state agency for 1 sampled resident, (#24) and a resident to resident altercation for 1 sampled resident, (#11).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #24's admission (MDS) Minimum Data Set assessment, dated 6/3/15, indicated the resident had a (BIMS) Brief Interview for Mental 	F 225			

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F 225	<p>Continued From page 5</p> <p>Status score of 6 which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff member for bed mobility, dressing, toileting, personal hygiene, and limited assistance for transfers, and ambulation. The assessment further revealed the resident had unsteady balance and had a history of falls.</p> <p>The initial care plan, dated 5/28/15, stated the resident was at risk for falls related to a history of falls, ambulated ad lib (at ones pleasure) with a roller walker, and needed direction to get from one destination to another.</p> <p>The 5/31/15 nurse's notes revealed the following: At 7:40 AM, staff heard a loud crash and found the resident standing by the bed with blood on the floor. The nurse's note further stated the resident had 2 skins tears with bruising around the elbow and left flank. The note stated the resident's left upper extremity had a 6 (cm) centimeter skin tear with bruising, and the resident had a 5 cm skin tear on his/her elbow with bruising. The notes stated the staff was unable to assess the resident due to he/she had gotten him/herself up.</p> <p>At 11:00 AM, the resident complained of pain, difficulty ambulating, and moaned when walking.</p> <p>At 11:30 AM, the facility attempted to contact the physician multiple times and received an order at 12:30 PM to transfer the resident to the local hospital.</p> <p>At 7:50 PM, the facility was notified the resident had left lower rib fractures.</p> <p>The 5/31/15 hospital discharge orders directed the facility staff to initiate fall preventions, and</p>	F 225		

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F 225	<p>Continued From page 6 resume nursing activities.</p> <p>The 5/31/15 x-ray report stated the resident had age-indeterminate fracture of the distal right clavicle and non-displaced rib fractures involving the left lower rib.</p> <p>The 6/3/15 at 11:53 AM, physician's progress note stated the resident had rib fractures and appeared to have a clavicle fracture and to continue medications.</p> <p>On 9/16/15 at 2:30 PM, observation revealed the resident seated in the special care unit living room. The resident was in his/her wheelchair in front of the tv. Further observation revealed the resident's legs moved up and down and the resident was restless and would hold his/her hand out towards the television. Continued observation revealed Nurse Aide F in Resident's #20's room with the door shut and Nurse Aide G had went into Resident #19's room. At 2:45 PM, the surveyor heard the resident holler "oh!", looked up, and observed the resident falling out of his/her wheelchair, and the personal alarm not sounding. The resident was lying on his/her right side, and the wheelchair was on its side. This surveyor went into Resident #19's room to get the nurse aide, and the aide went to Resident #20's room to get the second aide. Observation revealed Nurse Aide F called for a nurse to assess the resident so they could get him/her back into the wheelchair. Nurse C asked the nurse aides if the alarm sounded, Nurse Aide G stated, "No".</p> <p>On 9/17/15 at 9:45 AM, Nurse Aide L stated the resident was on a 15 minute visual check which he/she documented on his/her resident care sheet. (Review of the care sheet lacked</p>	F 225		

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F 225	<p>Continued From page 7</p> <p>documentation of the 15 minute visuals on 9/17/15 since 6:45 AM-3 hours). Nurse Aide L further stated there are to be two staff members in the unit at all times and if a resident required assistance of two staff, they had to call for another nurse aide to keep a visual on the residents in the special care unit. Nurse Aide L stated the resident required a personal alarm at all times.</p> <p>On 9/16/15 at 4:00 PM, Administrative Staff A stated the risk management department determines which incidents are called into the state agency.</p> <p>On 9/16/15 at 4:49 PM, Social Service Staff Q stated the fall had not been reported to the state agency because he/she thought the physician would do a follow up X-ray to make sure the fractures were from that fall. Social Service Staff Q further stated he/she should have followed up to see if the x rays were completed, then contacted the state agency.</p> <p>The 6/10/13 facility's Reporting Suspicion of a Crime Policy stated the injury of unknown origin should be reported as reasonable suspicion of a crime when the injury was not observed by any person.</p> <p>The facility failed to report cognitively impaired Resident #24's fall which resulted in a fractured clavicle and ribs.</p> <p>- Resident #11's (MDS) Minimum Data Set assessment, dated 7/12/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident was independent with eating, ambulation, bed</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>mobility, transfers, and required limited assistance of 1 staff member for toileting and dressing. The assessment further stated the resident had no behaviors, including rejection of care, or wandering.</p> <p>The 7/21/15 care plan indicated the resident was independent with ambulation but required cues and direction, and instructed staff to complete 15 minute visual checks.</p> <p>The 8/25/15 at 2:30 PM, nurse's note stated the resident was seated at a dining room table when another resident punched him/her in the stomach. The note further stated the 2 residents were separated and had no further altercations. The note stated the staff assessed the resident and he/she had no injury or complaint of pain. Review of the medical record lacked any further documentation of the altercation or of a follow up assessment.</p> <p>The 8/25/15 facility Risk Management Investigation stated Resident #11 went to sit down at a table with another couple. The report stated Resident #47 told Resident #11 to go sit elsewhere and when the resident did not leave, Resident #47 hit the resident in the stomach. The investigation indicated staff assessed Resident #11 and he/she had no redness or injury. The report stated both residents involved were interviewed and neither resident could recall the altercation. Resident #47's spouse stated they liked to be alone, and Resident #11 was not hit very hard. The report stated the staff were again educated about having only 2 chairs at the table and to allow the couple to have alone time.</p> <p>Review of the medical record and the investigation revealed Resident #11's responsible</p>	F 225			

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F 225	<p>Continued From page 9 party was not notified of the incident.</p> <p>On 9/17/15 at 11:45 AM, observation revealed Resident #11 at the dining room table eating lunch. Further observation revealed Resident #47, and his/her spouse at another table, with an additional empty chair at the table. (observed 3 of 4 onsite days in the facility)</p> <p>On 9/16/15 at 7:55 AM, Nurse Aide P stated the staff assisted Resident #11 at meal times with cueing and direction. Nurse Aide P further stated he/she did not know of a resident to resident altercation involving Resident #11 and did not know only 2 chairs were to be placed at Resident #47's table.</p> <p>On 9/16/15 at 4:00 PM, Administrative Staff A stated the risk management department determines which incidents are called into the state agency.</p> <p>On 9/16/15 at 4:54 PM, Social Service Staff Q stated Resident #11 sat down at the table with a couple that liked to eat alone and when Resident #11 didn't leave, Resident #47 hit Resident #11. Social Service Staff Q stated he/she reviewed the camera and Resident #47 did not punch the resident in the stomach as documented by staff, but he/she just lightly hit at the resident, so the incident was not reported. Social Service Staff Q further stated the staff had been educated twice to keep only 2 chairs at the couples table so they can eat alone.</p> <p>On 9/17/15 at 10:30 AM, Licensed Nurse D stated the staff sit with Resident #11 during meals and assisted him/her as needed. Licensed Nurse D further stated he/she did not know of a resident to resident altercation involving Resident #11.</p>	F 225			

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F 225	Continued From page 10 The 6/10/13 facility's Reporting Suspicion of a Crime Policy stated the administrator or his/her designee will notify the appropriate state licensing agency of the incident within the mandatory reporting time frame. The facility failed to report an altercation involving Resident #11, who was hit by another resident in the Special Care Unit	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to develop a comprehensive care	F 279		

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F 279	<p>Continued From page 11</p> <p>plan for 1 of 14 residents regarding incontinence. (#9)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #9's annual (MDS) Minimum Data Set assessment, dated 7/19/15, indicated the resident had a (BIMS) Brief Interview for Mental score of 15, (cognitively intact). The assessment revealed the resident independent with set up help with bed mobility, transfers, dressing, and toilet use. The assessment further revealed the resident was continent of bowel and bladder. <p>The 7/19/2015 (ADL) activities of daily living (CAA) Care Area Assessment, indicated the resident was able to dress, toilet, complete his/her own grooming and ambulate with a rolling walker. The CAAS indicated the resident required staff assistance with bathing.</p> <p>The 7/22/2015 care plan directed staff to assist the resident with(ADLs) Activities of Daily Living as needed and to check the resident's bedding daily, in the morning, even if the bed was made, to see it it needed to be changed. The staff would change the bedding as needed in addition to the weekly scheduled bed changes, and the nurse aide would pick up the dirty laundry every evening from the hamper in the resident's bathroom.</p> <p>The medical records revealed the physician ordered Ditropan (a medication used to treat overactive bladder and urinary conditions) XL 5 (mg) milligrams, 1 time a day for urinary incontinence (initiated 11/19/2013 - 22 months ago).</p>	F 279			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2015
NAME OF PROVIDER OR SUPPLIER CITIZENS MEDICAL CENTER LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 1625 S FRANKLIN AVE COLBY, KS 67701		
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F 279	<p>Continued From page 12</p> <p>The ADL aide documentation book revealed the resident had bathroom privileges, and had no body odor.</p> <p>The Bladder 7 day voiding check completed for the annual MDS from 7/13/15 thru 7/19/15 and the quarterly on 4/20/15 thru 4/26/15 indicated the resident had no problems identified.</p> <p>The 9/15/2015 at 4:04 PM, nurse's notes indicated the resident had been incontinent of urine, had a foul urine odor with urinary frequency, and denied pain or discomfort. The nurse left a message with the provider/physician to request a urinalysis (a test performed on urine to detect infections, acute and chronic conditions).</p> <p>The 9/16/2015 urinalysis culture and sensitivity report indicated the resident's urine had a few bacteria, trace of mucus and white blood cells 0-2. The 9/18/2015 sensitivity report indicated no growth.</p> <p>On 9/14/2015 at 3:31 PM, observation revealed the resident, seated in a recliner, in his/her room. Further observation revealed the resident's room had a strong pungent smell of urine.</p> <p>On 9/15/2015 at 8:20 AM, observation revealed the resident's bathroom had a strong pungent smell of urine.</p> <p>On 9/15/2015 at 3:50 PM Nurse Aide J verified lately the resident has had frequent urinary incontinence and his/her bed had been wet a lot of the time in the mornings and required frequent linen changes.</p>	F 279		

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F 279	<p>Continued From page 13</p> <p>On 9/17/2015 at 8:10 AM, Nurse Aide K verified the resident had left a wet night gown in his/her bathroom and the aide removed the gown. Nurse Aide K verified the resident's room continued to smell of urine, and verified his/her recliner had a strong urine smell.</p> <p>On 9/15/2015 at 3:08 PM, Administrative Nurse I investigated the residen'st room and verified it had a strong urine odor, and observed the resident's wet bed clothes in his/her hamper in the bathroom. Administrative Nurse I verified the resident's carpet in front of his/her bed had a strong urine smell and stated "the carpet needed to be cleaned". Administrative Nurse A verified the facility lacked a care plan for staff that instructed him/her of appropriate care for the resident identified with incontinence and he/she was at a high risk for developing urinary tract infections.</p> <p>The facility's 11/10/2014 bowel and bladder assessment policy stated that a bowel/bladder assessment is initiated on admission, readmission from the hospital, after a urinary catheter is removed, and /or as needed. The purpose of the policy is to provide a consistent procedure for monitoring and developing a toileting plan related to the resident's toileting pattern.</p> <p>The facility failed to provide a facility care plan to direct the staff for the care of Resident #9, who had urinary tract infections and incontinence.</p>	F 279			
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to provide the necessary care and services for 1 resident reviewed for behaviors related to bowel and bladder elimination. (#1) Findings included: - Resident #1's medical record revealed the 8/06/2015 physician's order sheet with diagnoses that included depressive disorder (a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or longer), obsessive compulsive disorder (excessive thoughts that lead to repetitive behaviors), nonorganic psychosis (a mental disorder characterized by a disconnection from reality), mental retardation (below average intellectual function, and a lack of skills necessary for daily living), anxiety (a feeling of worry, nervousness, or unease, about something that is uncertain) and rectal prolapsed (the rectal walls have prolapse and they protrude out of the anus). The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 6/07/2015, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3, which indicated severe cognitive impairment. The MDS indicated the resident was independent with transfers, walking in the room and corridor, locomotion on and off the unit, and required extensive assistance with dressing, and toilet use. The MDS indicated the resident had bowel and bladder incontinence and received antipsychotic and antidepressant</p>	F 309			

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F 309	<p>Continued From page 15 medications daily.</p> <p>The 6/14/2015 care plan, directed the staff to assist the resident with dressing, personal hygiene and bathing. The care plan indicated the resident had behavioral symptoms related to obsessive compulsive disorder as evidenced by repetitive behavior, physical movement, refusing medications, and obsessing over bowels. The care plan directed the staff to administer Ativan (antianxiety) and Risperdal (antipsychotic) for the behavior.</p> <p>The September 2015 physician's orders directed the staff to administer to the resident, the following antidepressant and antipsychotic medications:</p> <ol style="list-style-type: none"> 1) Zoloft, 100 (mg) milligrams, 1 a day, for depressive disorder 2) Risperdal, 0.25 mg, 1 tablet two times a day, for obsessive compulsive disorder 3) Ativan 1 mg, 1 x a day, for anxiety <p>On 9/16/2015 at 4:30 PM, observation revealed the resident standing beside his/her recliner with his/her pants and briefs down and his/her genital area exposed. The surveyor notified Administrative Nurse I and he/she went into the resident's room to assist him/her to the toilet.</p> <p>On 9/17/2015 at 7:15 AM, observation revealed the resident standing in the doorway of his/her room with an approximated 3 x 5 inch wet spot in the front of his/her light gray sweatpants, and down the inside of the right pant leg. The therapy staff started to assist the resident to the dining room and a nurse aide intervened and ask the resident to return to his/her room to change clothes.</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>On 9/17/2015 at 7:20 AM, observation revealed the resident standing in the middle of the 300 hall and he/she stated " I don't feel good" and then proceeded to pull his/her sweat pants and briefs down exposing his/her genitals. At that time, 1 staff and 1 resident ambulated by the resident toward the dining room. The surveyor requested staff assist the resident and an aide directed the resident to the bathroom and noted the resident had blood on his/her briefs. The aide alerted the nurse and the Nurse I examined the resident and indicated the rectum had not prolapsed and assisted the resident to pull his/her briefs up, then directed him/her to the dining room.</p> <p>Review of the behavioral monitoring intervention flow sheet revealed the following:</p> <p>5/29/2015 at 7:00 - 7:45 PM, after dinner the resident went back to his/her room and laid in the bed. The aide assisted other residents and returned to his/her room and assisted the resident to the toilet and he/she was clean and the resident did not use the toilet. After the aide took a break he/she returned to the residents room and noted feces smeared all over the walls, floor, toilet and sink. The aide cleaned the resident's room and then assisted the resident to clean him/herself up then assisted the resident to bed.</p> <p>9/05/2015 at 4:05 PM, the staff observed the resident down the 400 hall attempting to open the kitchen door because he/she wanted ice cream. Staff observed the resident had soiled pants and he/she did not have a brief on. The aide assisted</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>the resident to his/her room, proceeded to clean the resident, change his/her clothing, and the resident sat down in the recliner until supper.</p> <p>9/05/2015 at 4:20 PM, staff cleaned the resident's bathroom after the resident smeared feces everywhere. Staff observed the resident picking up some feces then washing his/her hand off in the toilet. The aide assisted the resident to wash his/her hands and he/she sat in the recliner until supper.</p> <p>Review of the 5/13/2014 psychotherapist progress notes revealed the resident presented with features of weight fluctuation, apathy, resistance to bathing, OCD, seclusion and depression. The therapist discussed the resident spending more time in his/her bed, his/her mood and relationships with staff, and the resident denied any new medical problems. The notes indicated the therapist focused on the resident's mood, and documented the resident had progressed toward his/her treatment goal.</p> <p>Review of the 6/17/2014 psychotherapist progress notes revealed the resident had been stable with his/her mood, behaviors, and health. The notes indicated the treatment goal currently had been met. The notes indicated the therapist recommended follow up treatment, and staff needed to know the resident's routine and moods.</p> <p>On 9/17/2015 at 7:25 AM, Nurse Aide K stated the resident was incontinent and wears incontinent briefs. Nurse Aide K stated the</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>resident would occasionally toilet him/herself. Nurse Aide K stated it was not unusual for the resident to pull his/her pants down.</p> <p>On 9/15/2015 at 2:10 PM, Nurse R stated the resident is frequently incontinent and frequently pulled down his/her pants. The staff assist the resident with toileting before and after meals, at bedtime and as needed. The resident will not tell the staff he/she was incontinent and staff have to check him/her. Nurse R stated the resident does dig in his/her rectum and staff try to redirect him/her when this occurs.</p> <p>On 9/19/2015 at 8:05 AM, Administrative Nurse I verified the resident had a rectal prolapse, would dig his/her feces out, to reduce the prolapsed rectum. Administrative Nurse I verified the resident does pull his/her pants and incontinent briefs down in public and staff attempt to redirect him/her. Administrative Nurse I verified the resident has not had any therapy and/or psychiatrist intervention since 6/2014 (15 months ago) and stated an appointment would be indicated for interventions for the resident's behavior.</p> <p>The facility's 5/14/2015 Consent for Services policy indicated each resident would be provided, or the facility would make arrangements with other health providers, for services for the resident as ordered. The facility would work with the resident and the attending physician to develop and maintain a written care plan.</p> <p>Upon request the facility did not provide a behavioral management policy.</p>	F 309			

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F 309	Continued From page 19 The facility failed to assess, document and seek medical intervention and psychosocial needs in order to provide the necessary care and services to maintain the highest practicable, physical, mental, and psychosocial well- being for Resident #1 who had obsessive compulsive behavior related to urine and bowel elimination.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to provide necessary services to maintain appropriate oral hygiene for 1 resident reviewed for (ADLs) Activities of Daily Living. (#13) Findings included: - Resident #13's significant change (MDS) Minimum Data Set assessment, dated 8/31/15, indicated the resident had a (BIMS) Brief Interview of Mental Status score of 0, which indicated severe cognitive impairment, dependent on 1 staff for eating, and had a feeding tube (tube for introducing high calorie fluids into the stomach). The MDS further indicated the resident had obvious cavity or broken natural teeth and received insulin, anticoagulant, and antibiotic medications.	F 312		

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F 312	<p>Continued From page 20</p> <p>The 9/8/15 care plan stated the resident was (NPO) nothing by mouth for all fluids and received medications and nutrition through a gastric tube (tube through the abdomen that delivers nutrition directly to the stomach) given by the nurse. The care plan directed the staff to provide oral care in AM and PM.</p> <p>On 9/15/15 at 2:09 PM, observation revealed staff provided incontinent cares to the resident, left the room, and no time oral care provided.</p> <p>On 9/15/15 at 4:13 PM, observation revealed the resident lying in his/her bed while nursing staff provided the scheduled tube feeding. Further observation revealed when the resident smiled, he/she had strings of mucous extending from the top to the bottom lip, on both sides of his/her mouth. The staff completed the tube feeding, did not provide oral care to the resident before leaving his/her room and observation revealed toothettes (mouth swabs) available in the top drawer of the resident's side table by the dresser.</p> <p>On 9/16/15 at 8:17 AM, observation revealed staff provided incontinent cares to the resident, and when the resident smiled strings of mucous were visible, from the top to the bottom lip, on both sides of his/her mouth. Further observation revealed the staff pushed the resident, seated in the wheelchair, from his/her room to the beauty shop and staff provided no oral care for the resident.</p> <p>On 9/16/15 at 4:21 PM, observation revealed the resident lying in his/her bed, while Nurse C provided the scheduled feeding and did not provide oral care to the resident before leaving his/her room.</p>	F 312			

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F 312	Continued From page 21 On 9/17/15 at 11:18 AM, Administrative Nurse A stated staff should provide the resident with oral cares when providing all other cares to the resident. The facility's 3/26/88 Oral Hygiene policy directed the staff to provide oral hygiene during every shift, and whenever necessary by rinsing out the resident's mouth with toothettes dampened with tepid (lukewarm) water. The facility failed to provide necessary oral care to maintain oral hygiene for Resident #13.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents of which 3 were reviewed for pressure ulcers. Based on observation, record review and interview, the facility failed to provide necessary treatment and services to prevent 1 of 3 sampled residents from developing a pressure ulcer on his/her right ankle, and worsening of the sacral pressure ulcer. (#54) Findings included:	F 314		

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F 314	<p>Continued From page 22</p> <p>- Resident #54's physician order sheet, dated 9/12/2015, revealed diagnoses of depression (a state of feeling sad, a mood disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent thinking, feeling of rejection and hopelessness), diabetes (the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and peripheral neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet).</p> <p>The quarterly (MDS) Minimum Data Set assessment, dated 6/04/2015 MDS indicated the resident was at risk for developing a pressure ulcer, did not have a pressure ulcer, had a pressure reducing device for his/her bed, and staff applied ointment /medications other than to the feet. The 8/23/2015, admission MDS indicated the resident had moderately impaired cognition, and required limited assistance with 1 staff for bed mobility, toilet use, personal hygiene, and extensive assistance with dressing. The MDS indicated the resident had a Stage I or greater pressure ulcer, and a Stage II pressure ulcer.</p> <p>The 6/11/2015 care plan indicated the resident was at risk for pressure ulcers, secondary to daily use of antiplatelet (medication to stop blood cells from sticking together and forming a blood clot) and a history of a Stage II pressure to his/her right ankle. The care plan indicated the staff would assist the resident to change position with meals, toileting, and at bedtime. The care plan directed the staff to have a pressure relieving cushion, in the chair, at all times, ensure a dressing to the resident's buttocks at all times,</p>	F 314		

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F 314	<p>Continued From page 23 and notify the nurse if the dressing is loose, soiled or missing.</p> <p>The 5/29/2015 admission skin assessment revealed the resident had the following wounds, right 2nd toe 0.1 x 0.2 cm, left great toe on the top -0.5 x 0.5 cm, and left 3rd toe 0.2 x 0.3 cm.</p> <p>The 5/29/2015 Braden assessment scale for predicting pressure sores, revealed a score of 16, and the 8/18/2015 Braden assessment, revealed a score of 17. A Braden score of 12 or less indicates high risk for pressure ulcer</p> <p>The 6/01/2015 nutritional progress note assessment indicated the resident received a regular diet, and ate an average of 65% of his/her meals. The assessment indicated the resident weighed 185#. The dietician made recommendations to the dietary department to provide snacks for the resident, three times a day.</p> <p>The 7/06/2015 nutritional progress notes indicated the resident had a Stage II pressure ulcer on his/her right ankle, and an open area on his/her buttocks. The dietician recommended the resident receive 2 tablespoons of protein powder three times a day, to equal 300 calories and 20 grams of protein.</p> <p>The 6/26/2015 untimed, nurse's notes indicated the nurse notified the physician of the resident's right ankle Stage II pressure ulcer.</p> <p>The 6/26/15 facility investigation revealed the physical therapy staff discovered an ulcer on the resident's right lateral ankle, after the therapist accidentally removed the resident's right sock instead of the left, that he/she had been providing</p>	F 314			

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F 314	<p>Continued From page 24 wound care to his/her toes.</p> <p>The 6/09/2015 physician's telephone order instructed the staff to cleanse the resident's open area to his/her left buttocks with normal saline, apply Biafine and cover with tegaderm every day, and as needed, if loose, soiled or missing.</p> <p>Physical Therapy Wound Care Pressure Ulcer treatment included the following: 6/26/2015 Right lateral ankle 0.3 (cm) centimeters x 0.4 cm x unknown depth with secondary slough (dead tissue separated from the living tissue). Resident was in his/her room at the time the ulcer discovered the wound cleansed with saline and 4x4's. Right lateral ankle covered with PolyMem (a dressing containing a cleanser, moisturizer and refined cornstarch, for treating ulcers) and hypafix (an adhesive, non woven fabric for dressing retention) tape.</p> <p>6/30/2015 Right ankle 0.3 cm x 0.2 cm x unknown 100% yellow slough. Wound debridment (removal of dead, damaged or infected tissue to improve the healing potential of the remaining healthy tissue. Documented no dressing present on any wounds at beginning of treatment.</p> <p>7/02/2015 Right ankle no size provided on Physical Therapy Wound Care Notes. Cleansed right lateral ankle with Anaccept wound cleanser and 4x4 gauze right ankle polymem quadrafoam covered with Hypafix tape. Documented no dressing present on right lateral ankle.</p> <p>7/07/2014</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>Right ankle 0.3 x 0.3 cm brown slough no drainage, no redness. Cleansed with anaccept cleansing saline and 4x4 wound dressing, topical applied for ankle.</p> <p>7/10/2015 Cleansed right lateral ankle and sacral area with anaccept wound cleanser and 4 x 4 gauze. Right lateral ankle area open to air, scabbed tissue intact. Nutrashield lotion and Allelyvn Life applied.</p> <p>7/14/2015 Right ankle with scabbed area, and scabbed tissue.</p> <p>The 7/22/2015 physician's order instructed the staff to cleanse the right ankle wound with normal saline, cover with polymem and hypofix as needed and if the dressing became loose, soiled or missing between physical therapy visits. Diagnosis as a Stage II decubits.</p> <p>The 6/25/2015 physician's telephone order instructed the staff to cleanse the mid sacral wound with saline with a 4x4 gauze sponge, apply nutrashield over the open areas and place Allelyvn over all 3 open areas.</p> <p>The 7/17/2015 physician's telephone order instructed the staff to obtain a wound culture of the resident's wound on the buttocks.</p> <p>The 7/20/2015 physician's telephone order instructed the nurse to start Bactrim (an antibiotic) double strength, 1 tablet twice a day, for 14 days for treatment of the open wound on the resident's buttocks.</p>	F 314		

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F 314	Continued From page 26 The 7/20/2015 10:20 PM nurse's notes indicated the resident had a coccyx wound that had been treated at the facility since the resident's admission on 5/29/2015. At the spouse's request the facility obtained a culture of the sacral pressure ulcer which revealed a diagnosis of (MRSA) Methacillin-resistant Staphylococcus aureus. The 7/21/2015 at 10:00 AM nurse's notes documented the facility informed the spouse of the resident's positive culture diagnosis and the need for contact isolation (a form of isolation in which anyone entering the patient's room and having direct contact with the patient would wear gown and gloves). The 7/21/2015 at 3:30 PM nurse's notes indicated the physician ordered Bactrim, twice a day, for 14 days, for treatment of the open wound to his/her buttocks. The 9/02/2015 telephone order indicated the physician ordered Cipro (an antibiotic) 500 (mg) milligrams, 1 tablet twice a day, for 14 days, for treatment of the open wound to his/her buttocks. The 9/03/2015 telephone order indicated the physician ordered the staff to discontinue the right medial sacral wound treatment of normal saline and a 4 x 4 gauze and ordered to start Biafine topically, cover with a tegaderm daily, and as needed when loose, soiled or missing. The order instructed the staff to cleanse the right sacral wound with Dakins solution 0.125% with a 4x 4 gauze pad then apply Biafine topically and cover with tegaderm daily, and as needed, if loose, or missing, for treatment of the MRSA.	F 314		

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F 314	<p>Continued From page 27</p> <p>On 9/16/2015 at 10:00 AM, observation revealed Nurse H gowned and gloved, had the resident stand in front of his/her recliner then removed the tegaderm from the sacral wound and cleansed the area with normal saline and a 4x4 gauze sponge. Nurse H applied Biafin topical ointment with a sterile q-tip swab and placed a tegaderm cover dressing over the sacral wound.</p> <p>On 9/16/2015 at 11:10 AM, Administrative Nurse A verified the resident had toe and sacral wounds upon admitted to the facility. Administrative Nurse A verified the resident developed the right ankle wound in the facility. Administrative Nurse A verified the physician order the dressing change to the residents coccyx was cleanse with normal saline, next Dakins solution then apply the Baifin ointment. Administrative Nurse A verified the Dakins solution would clear up the MRSA infection.</p> <p>The facility's 1/12/2015 Skin Integrity Management policy indicated a licensed nurse would provide head to toe assessment upon admission, readmission, quarterly, and or any time there is significant change in a resident's condition occurs. The policy stated that resident's admitted to the facility without pressure ulcers, will not develop pressure ulcers, unless a resident's clinical condition demonstrates that they were unavoidable. Residents will have a treatment plan for maintenance of skin integrity and wound management if required. The policy provided guidelines to identify the residents at risk for skin breakdown, reduce or relieve pressure and maintain skin integrity, and provide</p>	F 314			

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F 314	Continued From page 28 appropriate interventions to manage pressure ulcers. The charge nurse will assess all reported abnormal skin conditions/breakdown, and a skin breakdown communication tool would be completed. The abnormal skin conditions/breakdowns that require treatment or those that are pressure ulcer should be documented on the interdisciplinary notes of the resident's chart with each treatment or at least weekly. The facility failed to implement preventative measures to prevent the development of pressure sores to Resident #54's right ankle, and failed to provide the physician ordered Dakins solution to his/her sacral wound.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents of which 3 were reviewed for urinary incontinence. Based on observation, record review and interview the facility failed to provide 1 of 3 residents with an assessment, monitoring, and approaches to care for urinary incontinence. (#9)	F 315		

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F 315	<p>Continued From page 29</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #9's annual (MDS) Minimum Data Set assessment, dated 7/19/15, indicated the resident had a (BIMS) Brief Interview for Mental score of 15, (cognitively intact). The assessment revealed the resident independent with set up help with bed mobility, transfers, dressing, and toilet use. The assessment further revealed the resident was continent of bowel and bladder. <p>The 7/19/2015 (ADL) activities of daily living (CAA) Care Area Assessment, indicated the resident was able to dress, toilet, complete his/her own grooming and ambulate with a rolled walker. The CAAS indicated the resident required staff assistance with bathing.</p> <p>The 7/22/2015 care plan directed staff to assist the resident with (ADLs) Activities of Daily Living as needed and to check the resident's bedding daily, in the morning, even if the bed was made, to see if it needed to be changed. The staff would change the bedding as needed in addition to the weekly scheduled bed changes, and the nurse aide would pick up the dirty laundry every evening from the hamper in the resident's bathroom.</p> <p>The medical records revealed the physician ordered Ditropan (a medication used to treat overactive bladder and urinary conditions) XL 5(mg) milligrams, 1 time a day for urinary incontinence (initiated 11/19/2013 - 22 months ago)</p> <p>The ADL aide documentation book revealed the resident had bathroom privileges, and had no</p>	F 315			

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F 315	<p>Continued From page 30 body odor.</p> <p>The Bladder 7 day voiding check completed for the annual MDS from 7/13/15 thru 7/19/15 and the quarterly on 4/20/15 thru 4/26/15 indicated the resident had no problems identified.</p> <p>The 9/15/2015 at 4:04 PM, nurse's notes indicated the resident had been incontinent of urine, had a foul urine odor with urinary frequency, and denied pain or discomfort. The nurse left a message with the provider/physician to request a urinalysis (a test performed on urine to detect infections, acute and chronic conditions).</p> <p>The 9/16/2015 urinalysis culture and sensitivity report indicated the resident's urine had a few bacteria, trace of mucus and white blood cells 0-2. The 9/18/2015 sensitivity report indicated no growth.</p> <p>On 9/14/2015 at 3:31 PM, observation revealed the resident, seated in a recliner, in his/her room. Further observation revealed the resident's room had a strong pungent smell of urine.</p> <p>On 9/15/2015 at 8:20 AM, observation revealed the resident's bathroom had a strong pungent smell of urine.</p> <p>On 9/15/2015 at 3:50 PM Nurse Aide J verified lately the resident has had frequent urinary incontinence and his/her bed had been wet a lot of the time in the mornings and required frequent linen changes.</p>	F 315		

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F 315	Continued From page 31 On 9/17/2015 at 8:10 AM, Nurse Aide K verified the resident had left a wet night gown in his/her bathroom and the aide removed the gown. Nurse Aide K verified the resident's room continued to smell of urine, and verified his/her recliner had a strong urine smell. On 9/15/2015 at 3:08 PM, Administrative Nurse I investigated the resident's room and verified it had a strong urine odor, and observed the resident's wet bed clothes in his/her hamper in the bathroom. Administrative Nurse I verified the resident's carpet in front of his/her bed had a strong urine odor. The facility's 11/10/2014 bowel and bladder assessment policy stated that a bowel/bladder assessment is initiated on admission, readmission from the hospital, after a urinary catheter is removed, and /or as needed. The purpose of the policy is to provide a consistent procedure for monitoring and developing a toileting plan related to the resident's toileting pattern. The facility failed to provide toileting and incontinent care for Resident #9, who had a history of urinary tract infection and a strong smell of urine in his/her room.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	<p>Continued From page 32 prevent accidents.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents of which 2 were reviewed for accidents. Based on observation, record review and interview, the facility failed to ensure that the resident environment remained as free of accident hazards as possible for 1 resident who had falls with injury (#24), and failed to provide supervision for Resident #11, who had a resident to resident altercation.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #24's significant change (MDS) Minimum Data Set assessment, dated 8/25/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident required extensive assistance with bed mobility and dependent upon 2 staff members for transfers and toileting. The assessment further revealed the resident had unsteady balance, did not ambulate and had a history of falls. <p>The 9/1/15 fall (CAA) Care Area Assessment stated the resident was at risk and had a history of falls. The CAA further stated the resident was non weight bearing on his/her right leg and required a full body lift for transfers.</p>	F 323		

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F 323	<p>Continued From page 33</p> <p>The 9/1/15 care plan directed the staff to place a personal alarm on the resident at all times, visualize the resident every 15 minutes, change the residents position each meal, and lay the resident down for 1 hour after lunch.</p> <p>The 9/13/15 at 4:10 PM, nurse's note stated a kitchen staff member found the resident on the floor in his/her room. The note further stated the resident complained of pain to his/her left elbow. The note stated the staff cleaned the resident's left elbow with normal saline, applied steri strips, and covered his/her left elbow with a Band-Aid. The note stated the personal alarm was not on. (as directed by the plan of care)</p> <p>The 9/13/15 fall assessment form indicated the resident's personal alarm was not turned on.</p> <p>The 9/16/15 at 2:45 PM, nurse's note stated the resident fell out of his/her wheelchair onto his/her right side. The note stated the resident had skin tears to his/her right elbow, right forehead, and a small abrasion to his/her right ear. The note further stated the resident's personal alarm never sounded, the clip on the alarm was closed and in locked position. The note stated the personal alarm was in working order. The note stated the staff assisted the resident into his/her wheelchair with the use of the lift, and the resident stated he/she wanted "to go" and tried to lean forward in the wheelchair.</p> <p>The 9/16/15 fall assessment form indicated the staff did not lay the resident down after lunch and the resident's personal alarm was not turned on.</p>	F 323			

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F 323	Continued From page 34 On 9/16/15 at 2:30 PM, observation revealed the resident seated in the special care unit living room. The resident was in his/her wheelchair in front of the tv. Further observation revealed the resident's legs moved up and down and the resident was restless and would hold his/her hand out towards the television. Continued observation revealed Nurse Aide F in Resident #20's room with the door shut and Nurse Aide G was in Resident #19's room. At 2:45 PM, the surveyor heard the resident holler "oh!", looked up, and observed the resident falling out of his/her wheelchair, and the personal alarm not sounding. The resident was lying on his/her right side, and the wheelchair was on its side. This surveyor went into Resident #19's room to get the nurse aide, and the aide went to Resident #20's room to get the second aide. Observation revealed Nurse Aide F called for a nurse to assess the resident so they could get him/her back into the wheelchair. Nurse C asked the nurse aides if the alarm sounded, Nurse Aide G stated, "No". The 9/16/15 at 8:30 PM, nurse's note stated the resident was restless, moving his/her legs while in bed, and the staff requested the physician order medication for restless leg syndrome for the resident. On 9/17/15 at 11:43 AM, observation revealed the resident seated in his/her wheelchair at a dining room table eating lunch. Further observation revealed the resident with a Band-Aid to the right side of his/her forehead. On 9/16/15 at 2:27 PM, Nurse Aide G stated the	F 323			

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F 323	<p>Continued From page 35</p> <p>resident would usually lay down in the afternoon but he/she had been watching tv so they decided to let him/her stay up.</p> <p>On 9/16/15 at 3:00 PM, Nurse C stated the staff should lay the resident down in bed after lunch and check to make sure the personal alarm is attached.</p> <p>On 9/16/15 at 4:05 PM, Administrative Staff A stated the residents in the special care units should not be left alone in the commons area and if a resident required 2 staff members for cares, they should call for staff assistance. Administrative Staff A stated the staff should have made sure the resident's personal alarm was attached and functional.</p> <p>On 9/17/15 at 9:45 AM, Nurse Aide L stated the resident was on a 15 minute visual check which he/she documented on his/her resident care sheet. (Review of the care sheet lacked documentation of the 15 minute visuals on 9/17/15 since 6:45 AM- 3 hours). Nurse Aide L further stated there are to be two staff members in the unit at all times and if a resident required two staff assistance, they had to call for another nurse aide to keep a visual on the residents in the special care unit. Nurse Aide L stated the resident required a personal alarm at all times.</p> <p>The 1/12/15 facility Falls Education and Management Policy stated the purpose of the policy was to assess the residents' risk for falls, manipulation of the environment to prevent falls, and appropriate management of those who experience a fall. The policy directed the staff to assess the resident for any obvious injuries and determine what happened. The policy further</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>directed the charge nurse to make changes to the Plan of Care and Activities of Daily Living worksheets.</p> <p>The facility failed to ensure the resident's environment remained free of accident hazards and provide supervision for Resident #24, who had a history of falls, directed staff to ensure a personal alarm on, 15 minute checks completed, and resident laid down in bed after lunch as outline by the plan of care.</p> <p>- Resident #11's (MDS) Minimum Data Set assessment, dated 7/12/15, indicated the resident had long and short term memory problems with severely impaired decision making skills. The assessment revealed the resident was independent with eating, ambulation, bed mobility, transfers, and limited assistance of 1 staff member for toileting and dressing. The assessment further stated the resident had no behaviors, including rejection of care, or wandering.</p> <p>The 7/21/15 care plan indicated the resident was independent with ambulation but required cues and direction, and instructed staff to complete 15 minute visual checks.</p> <p>The 8/25/15 at 2:30 PM, nurse's note stated the resident was seated at a dining room table when another resident punched him/her in the stomach. The note further stated the staff seperated the 2 residents and no further altercations ocured. The note stated the staff assessed the resident and he/she had no injury or complaint of pain. Review of the medical record lacked any further documentation of the altercation or of a follow up assessment.</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>The 8/25/15 facility Risk Management Investigation stated Resident #11 went to sit down at a table with another couple. The report stated Resident #47 told Resident #11 to go sit elsewhere and when the resident did not leave, Resident #47 hit the resident in the stomach. The investigation indicated staff assessed Resident #11 and he/she had no redness or injury. The report stated both residents involved were interviewed and neither resident could recall the altercation. Resident #47's spouse stated they liked to be alone, and Resident #11 was not hit very hard. The report stated the staff were again educated about having only 2 chairs at the table and to allow the couple to have alone time.</p> <p>Review of the medical record and the investigation revealed Resident #11's responsible party was not notified of the incident.</p> <p>On 9/17/15 at 11:45 AM, observation revealed Resident #11 at the dining room table eating lunch. Further observation revealed Resident #47, and his/her spouse at another table, with an additional empty chair at the table. (observed 3 of 4 onsite days in the facility)</p> <p>On 9/16/15 at 7:55 AM, Nurse Aide P stated the staff assisted Resident #11 at meal times with cueing and direction. Nurse Aide P further stated he/she did not know of a resident to resident altercation involving Resident #11 and did not know only 2 chairs were to be placed at Resident #47's table.</p> <p>On 9/16/15 at 4:54 PM, Social Service Staff Q stated Resident #11 sat down at the table with a couple that liked to eat alone and when Resident #11 didn't leave, Resident #47 hit Resident #11.</p>	F 323		

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F 323	Continued From page 38 Social Service Staff Q stated he/she reviewed the camera and Resident #47 did not punch the resident in the stomach as documented by staff, he/she just lightly hit at the resident. Social Service Staff Q further stated the staff had been educated twice to keep only 2 chairs at the couples table so they can eat alone. On 9/17/15 at 10:30 AM, Licensed Nurse D stated the staff sit with Resident #11 during meals and assist him/her as needed. Licensed Nurse D further stated he/she did not know of a resident to resident altercation involving Resident #11. Upon request a policy for Resident to Resident Altercation was not provided by the facility. The facility failed to provide supervision for Resident #11 who was hit by another resident in the Special Care Unit, and provide an intervention of no extra chairs at the other resident's table to prevent further incidents.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents. Based on observation, record review, and interview, the	F 371		

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F 371	<p>Continued From page 39</p> <p>facility failed to store, prepare, and serve food under sanitary conditions for 47 of 48 residents, who resided in the facility, and received their meals from the facility kitchen.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 9/14/15 at 10:42 AM, during the initial kitchen tour, observation revealed the following: Dietary Staff E assisted with meal preparation and Dietary Staff N washed dishes, both had approximately 2 inches of hair hanging out of the back of their hairnets. On 9/14/15 at 11:36 AM, during the initial dining observation, Dietary Staff E delivered plates of food to the residents, in the special care unit, with approximately 2 inches of hair hanging out of the back of his/her hairnet. On 9/16/15 at 11:21 AM, during the full tour of the kitchen, observation revealed the following: Dietary Staff E and O assisted with meal preparation and had approximately 1 - 2 inches of hair hanging out of the back of their hairnets. On 9/16/15 at 12:09 PM, Dietary Staff F verified all dietary staff should have their hair completely contained in hair nets when preparing and serving food. <p>The facility's 2/14/11 Infection Control Policy stated employees should have hair covered with a hair net to promote appropriate food handling and food safety, throughout the organization.</p> <p>The facility failed to prepare and serve food under sanitary conditions for the 47 residents who resided in the facility and received meals from the facility kitchen.</p>	F 371			

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F 441 F 441 SS=F	Continued From page 40 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441		

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F 441	<p>Continued From page 41</p> <p>This Requirement is not met as evidenced by: The facility had a census of 48 residents. The sample included 14 residents. Based on observation, record review and interview, the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection for all the residents residing in the facility including Resident #54, on isolation precautions for (MRSA) methacillin resistant staph aureus (a bacteria that is highly resistant to methacillin, penicillin and other antibiotics) and #13, on isolation precautions for (VRE) Vancomycin-resistant Enterococci (a type of bacteria that have developed resistance to many antibiotics).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #54's physician order sheet, dated 9/12/2015, revealed diagnoses of depression (a state of feeling sad, a mood disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent thinking, feeling of dejection and hopelessness), diabetes (the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and peripheral neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). <p>The admission (MDS) Minimum Data Set assessment, dated 8/23/2015, indicated the resident had moderately impaired cognition, and required limited assistance with 1 staff for bed mobility, toilet use, personal hygiene and extensive assistance with dressing. The MDS</p>	F 441		

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F 441	<p>Continued From page 42</p> <p>indicated the resident had a Stage I or greater pressure ulcer, and a Stage II pressure ulcer. The 6/04/2015 admission MDS indicated the resident was at risk for developing a pressure ulcer, did not have a pressure ulcer, had a pressure reducing device for his/her bed, and staff applied ointment/medications other than to the feet.</p> <p>The 6/11/2015 care plan indicated the resident was at risk for pressure ulcers, secondary to daily use of antiplatelet (a medications that stop blood cells from sticking together and forming a blood clot) and a history of a Stage II pressure to the right ankle. The care plan indicated the staff would assist the resident to change position with meals, toileting, and at bedtime. The care plan directed the staff to have pressure relieving cushion, in the chair, at all times. The resident was to have a dressing to buttocks, at all times, and notify the nurse if it becomes loose, soiled or missing.</p> <p>On 9/17/2015 at 10:25 AM, observation revealed Housekeeping Staff S prepared to clean the resident room, put on gown, gloves, and entered Resident #54's room, who was on isolation precautions for MRSA. Housekeeping Staff S cleaned the resident's room, gathered the trash from the resident's bathroom, and a big trash can beside the resident's recliner, containing multiple used gloves, used gauze dressings, tegaderm, and other trash, and placed the collected trash into the housekeeping cart along with other trash.</p> <p>On 9/17/2015 at 11:20 AM, Housekeeping Staff S stated the red bags are for blood and fluids, observation revealed no red (hazardous waste) trash bags on the housekeeping cart and</p>	F 441			

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F 441	<p>Continued From page 43</p> <p>maintenance would take the red bagged trash to the hospital for trash pick up.</p> <p>On 9/17/2015 at 11:31 AM, Administrative Staff A stated the only thing right now that the facility places in the red bags is sharps, which then is stored in the medication room. Administrative Staff A stated the regular trash bags are used for a lot of blood or fluids when it would go immediately over to the hospital.</p> <p>The facility's Infection Control Isolation and Precautions Guidelines policy, dated 10/11/2010, stated when contact precautions were implemented, gowns and gloves must be worn upon entering the resident's room by all providers. Resident care equipment and articles are prudent or required, including the likelihood of contamination with infective material, the ability to cut, stick or otherwise cause injury, the severity of the associated disease, and the environmental stability of the pathogen involved. Some used articles are enclosed in containers or color coded bags to prevent inadvertent exposure to patients, residents, personnel and visitors and to prevent contamination of the environment. Used sharps are placed in puncture resistant containers; other articles are placed in a color coded bag.</p> <p>The facility failed to follow contact isolation precautions by placing the gloves and dressings in the regular trash from the room occupied by Resident #54, who was positive for MRSA, to prevent the transmission of disease or infection.</p> <p>- Resident #13's significant change (MDS) Minimum Data Set assessment, dated 8/31/15, indicated the resident had a (BIMS) Brief Interview of Mental Status score of 0, which</p>	F 441			

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F 441	<p>Continued From page 44</p> <p>indicated severe cognitive impairment, dependent on 1 staff for eating, had a feeding tube (tube for introducing high calorie fluids into the stomach), and received insulin, anticoagulant, and antibiotic medications.</p> <p>The 9/8/15 care plan indicated the resident was on contact isolation for (VRE) Vancomycin-resistant Enterococci (a type of bacteria that have developed resistance to many antibiotics) in his/her urine.</p> <p>On 9/15/15 at 9:54 AM and 4:13 PM, observations revealed Nurse H entered the resident's room, he/she walked past the disposable protective gowns, did not put on a gown, and proceeded to administer the resident's medications and scheduled feedings.</p> <p>On 9/15/15 at 2:09 PM, observation revealed Nurse Aide B placed a urine and bowel soiled brief and wipes into a regular trash bag. Further observation revealed Nurse Aide M tied the trash bag, took it to the soiled utility room, and placed the contaminated trash from the VRE positive room into the regular trash.</p> <p>On 9/16/15 at 8:17 AM, Nurse Aide B placed urine soiled brief and wipes into a regular trash bag in the resident's room, tied up the bag and took it to the soiled utility room, where the trash bag was placed into the regular trash.</p> <p>On 9/17/15 at 9:25 AM, Nurse D stated staff were expected to wear gowns and gloves when doing any type of cares with the resident due to the VRE in the resident's urine.</p> <p>On 9/17/15 at 11:18 AM, Administrative Nurse A stated staff should put on gowns prior to</p>	F 441		

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F 441	<p>Continued From page 45 administering medications and feedings to the resident because of the contact isolation precautions.</p> <p>The facility's Infection Control Isolation and Precautions Guidelines policy, dated 10/11/2010, stated when contact precautions were implemented, gowns and gloves must be worn upon entering the resident's room by all providers and staff.</p> <p>The facility failed to follow contact isolation precautions by gowning and gloving before providing cares to Resident #13, who was positive for VRE, to prevent the transmission of disease or infection and by placing trash from the VRE positive room in with the regular trash.</p>	F 441			