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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165238	A. BUILDING _____ B. WING _____	07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DENISON CARE CENTER	1202 RIDGE ROAD DENISON, IA 51442

(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 Correction date: 7/26/17 The following deficiencies were identified during the facility's annual survey and compliant investigation. Complaint #65836-C was not substantiated Complaint #69146-C was substantiated. See Code of Federal Regulations(45 CFR) Part 483, Subpart B-C.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		7/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Cullen — TITLE: LNHA — (X6) DATE: 8/7/17

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.

Deanna Pontzi, LNHA 8-23-17

POC accepted 8/24/17 KK

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview the facility failed to notify a resident's physician of held insulin for 1 of 11 residents reviewed (Resident #11). The facility reported a census of 36. Findings include: 1. The Minimum Data Set assessment dated 6/19/17 noted Resident #11 had a BIMS (Brief Interview for Mental Status) score of 14, indicating intact memory and cognition. The resident had diagnoses that included diabetes	F 157		

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F 157	Continued From page 2 mellitus and obesity. The assessment documented Resident #11 received daily insulin injections. During observation of medication pass on 7/11/17 at 11:20 a.m., Staff A, LPN (Licensed Practical Nurse) drew up 2 units of Humalog Solution for Resident #11 out of a vial with a sticker showing the vial had been opened on 6/6/17. When asked how long the vial of insulin was good for after opened, Staff A stated 28 days and this is outdated. The lid of the storage bottle had date of 7/7/17 written on it. When Staff A was asked if that was the date to dispose of the vial, Staff A did not think so. Staff A then discarded the syringe and the vial of insulin and went to the medication room to get a new vial for Resident #11. Staff A stated the facility did not have another vial in the facility and she would order one from the pharmacy. Staff A did not provide the ordered medication for the resident. The July 2017 Medication Administration Record (MAR) showed Resident #11 had an order for Humalog (insulin) inject per sliding scale before meals and at bedtime. The order had a start date of 6/6/17. On 7/11/17 at 11:00 a.m. the resident blood sugar measured 179; the order directed staff to administer 2 units of insulin. The form showed documentation at 11:00 a.m. of the medication refused (see nurse notes). Review of the MAR showed the resident had received 11 doses of insulin after the vial should have been discarded on 7/7/17. Resident #11's Progress Note for 7/11/17 at 11:29 a.m. noted Humalog Solution as not given and the medication not available. The resident's Progress Notes did not include documentation	F 157		

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F 157	Continued From page 3 that staff notified the resident's physician of medication not given. During interview on 7/12/17 at 11:15 a.m. Staff A stated she did not notify Resident #11's physician that she had been unable to provide the resident's 11:00 a.m. insulin order due to medication not available.	F 157		
F 225 SS=K	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect,	F 225	7/13/17	~~7/13/17~~ 7-19-17 D.P.

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F 225	Continued From page 4 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews with residents and staff, record review, and facility policy review, the facility failed to: investigate allegations of possible abuse, failed to immediately report	F 225		

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F 225	Continued From page 5 allegations of abuse to the State Survey Agency; and failed to report the outcome of the investigation to the State Survey Agency. This deficient practice represented a systemic failure by management that resulted in a determination of Immediate Jeopardy, that directly affected two (2) of eleven (11) residents (Resident #11 and Resident #12) in the sample; and had the potential to affect other residents due to management's lack of reporting and investigating. The Immediate Jeopardy (IJ) was identified during the investigation on 7/13/17 at 12:57 p.m. The facility reported a census of 36 residents. Findings include: 1. According to the Minimum Data Set with assessment reference date 6/19/17 Resident #11 had a BIMS score of 14, which meant he/she had intact cognitive skills for daily decision making. The resident had not displayed any behavior symptoms, hallucinations or delusions. Resident #11 required extensive assist of two staff for bed mobility, transfers, ambulation and toilet use. During an Interview with Resident #11 on 7/11/17 at 3:20 p.m. he/she stated one night he/she had a lot of leg pain and Staff F, certified medication aide (CMA) made the comment, "Do I need to hang you from your neck?" Resident #11 stated he/she had spoken of the situation to the Administrator. During interview on 7/11/17 at 4:25 p.m. the prior Administrator stated about three weeks ago Resident #11 and the resident's family member had called him to the resident's room to visit. The resident had told him about Staff F who the resident had called into the resident's room	F 225		

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F 225	Continued From page 6	F 225		

several times the night before because the resident had leg pain. Resident #11 told the Administrator that Staff F had stated to the resident, "I am going to hang you by your neck" or "stand you on your head". Resident #11 said Staff F and the resident had a rough night but the resident did not feel it was an appropriate response. The Administrator stated he asked the resident if he/she wanted to file a grievance report and the resident did not want to.
The Administrator stated he did not report the allegation of abuse and did not investigate the incident. The Administrator stated it was an error in judgement and at a loss of what to do now. He stated he would start an investigation and file a late, late report.

2. According to the Minimum Data Set with assessment reference date of 5/15/17, Resident #12 had a BIMS score of 9, which revealed moderate impaired cognitive skills for daily decision making. The resident had not displayed any behavior symptoms, hallucinations or delusions. Resident #12 required limited assist of one staff for bed mobility, transfers, ambulation and toilet use.

During interview on 7/12/17 at 4:28 p.m. Staff G, certified nurse aide (CNA) stated Resident #12 had told her that Staff H (Registered Nurse) had seen him/her standing up with his/her walker and told the resident," Better sit down because I do not want to pick your sorry ASS off the floor if you fall."
Staff G stated she had told the prior Director of Nursing (DON) directly because she thought it was critical. Staff G stated the prior DON said they are working on it, we do not have a lot of Registered Nurses and Staff H is a Registered

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F 225	Continued From page 7 Nurse. Staff G stated she told the DON we have to do something and the prior DON responded the Administrator thinks we are picking on Staff H. During interview on 7/13/17 at 9:30 a.m. Resident #12 stated staff treated him/her good when he/she is doing right and when not doing right staff are rude. The resident stated he/she had been told, "if you fall down I am not going to pick your sorry ASS up." Resident #12 stated it was Staff H that said that to him/her. Resident #12 then asked if that staff member was standing behind him/her. The resident was assured Staff H was not in the building. The resident stated Staff H had helped him/ her with medications and cares since making the statement. Resident #12 felt like Staff H did not like him/her denied being afraid of Staff H. Resident #12 then began to cry softly. The resident was unable to state when [approximate date] the incident had occurred. Resident #12 stated she had told Staff G of the incident. During interview on 7/17/17 at 11:25 a.m. the prior Director of Nurses (DON) stated she had heard from Staff G that Staff H had made the comment to Resident #12, "[you] better sit down because I do not want to pick your sorry ASS off the floor if you fall." The prior DON stated she thought she heard it last month, guessing, since after Resident #12's last fall on 6/18/17. The prior DON stated she had not had a chance to talk to Staff H or Resident #12 about it. The prior DON stated she knew it needed to be investigated and then if it was valid would report it after the investigation. The Abuse Prevention Program and Reporting	F 225		

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F 225	Continued From page 8 Policy with revised date 04/17 noted the facility acknowledges the following Federal definition of Verbal Abuse; oral, written, or gestured language that willfully includes disparaging and derogatory terms to the resident or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy included Reporting, directing staff to report the incident immediately to the Administrator and Director of Nursing. Any staff member with knowledge of the event is responsible for notifying the Administrator and/or DON. Notify the appropriate State agency immediately by fax, telephone or on-line reporting after identification of alleged/suspected incident. The facility abated the IJ on 7/13/17 when they completed the following: The Interim Administrator began education with staff regarding the facility Abuse Program and Reporting Policy on 7/12/17. On 7/13/17, the facility started on going education with staff on the Abuse Prevention Program and Reporting policy and facility Grievance Process. Staff were not allowed to work until they were educated. Staff were given a copy of the abuse policy and acknowledged a shared knowledge of understanding of what to do if there is an allegation of abuse, unkind or inconsiderate care towards a resident that they will report it to the Administrator and DON immediately. The facility provided training documentation to the State Agency (Department of Inspections and Appeals) which showed employees scheduled to work had been educated. The education provided by the management staff revealed the Administrator or designee daily will ensure prompt and appropriate follow-up in	F 225		

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F 225	Continued From page 9 accordance with the facility's abuse and grievance policy. The facility would have departments heads meet with assigned residents on a regular basis using the Guardian Angel tool to proactively address concerns with residents as a part of the facility ongoing quality assurance process. Staff F was suspended by the prior Administrator at 10:00 p.m. on 7/11/17 pending an investigation. The prior Administrator was suspended by the interim DON, regional nurse consultant the evening of 7/12/17. These actions lowered the IJ from "K" severity to D with ongoing monitoring of the facility policy for reporting and investigating abuse.	F 225		
F 226 SS=K	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95	F 226		7/31/17 7-19-17 D.P

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F 226	Continued From page 10 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interviews with residents and staff, review of the facility policy, the facility failed to implement their abuse policy and procedure to report and investigate all allegations of possible abuse; and failed to carry out reporting requirements to the State Survey Agency. This deficient practice represented a systemic failure by management that resulted in a determination of Immediate Jeopardy. The Immediate Jeopardy (IJ) was identified during the investigation on 7/13/17 at 12:57 p.m. The facility reported a census of 36 residents. Findings include: The Abuse Prevention Program and Reporting Policy with revised date 04/17 noted when the facility received an allegation of abuse, they must report immediately, (as soon as possible, but not to exceed 24 hours); separate the alleged perpetrator from all potential victims and begin	F 226		

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F 226	Continued From page 11	F 226		

their investigation.
Under Protection, staff are directed to immediately separate the resident from the alleged perpetrator. In the case of a direct care giver being suspected of alleged abuse the Administrator,(in their absence, the DON, ADON, Charge Nurse, in that order) must immediately relieve the individual of their duties without pay (suspend) until the investigation is complete.
The policy included Reporting, the policy directed staff to notify the shift supervisor if suspected abuse, neglect, mistreatment or misappropriation of property occurs. Report the incident immediately to the Administrator and Director of Nursing. Any staff member with knowledge of the event is responsible for notifying the Administrator and/or DON. Notify the appropriate State agency immediately by fax, telephone or on-line reporting after identification of alleged/suspected incident.

During an Interview with Resident #11 on 7/11/17 at 3:20 p.m. he/she stated one night he/she had a lot of leg pain and Staff F, certified medication aide (CMA) made the comment, "Do I need to hang you from your neck?" Resident #11 stated he/she had spoken of the situation to the Administrator.

During interview on 7/11/17 at 4:25 p.m. the prior Administrator stated about three weeks ago Resident #11 and the resident's family member had called him to the resident's room to visit. The resident had told him about Staff F who the resident had called into the resident's room several times the night before because the resident had leg pain. Resident #11 told the Administrator that Staff F had stated to the resident, "I am going to hang you by your neck" or "stand you on your head". The Administrator

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F 226	Continued From page 12 stated he asked the resident if he/she wanted to file a grievance report and the resident did not want to. The Administrator stated he did not report the allegation of abuse and did not investigate the incident. The Administrator stated it was an error in judgement and at a loss of what to do now. He stated he would start an investigation and file a late, late report. During interview on 7/11/17 at 10:05 p.m. Staff F stated she still works with Resident #11 whenever he/she turns on call light. 2. During interview on 7/12/17 at 4:28 p.m. Staff G, certified nurse aide (CNA) stated Resident #12 had told her that Staff H (Registered Nurse) had seen him/her standing up with his/her walker and told the resident," Better sit down because I do not want to pick your sorry ASS off the floor if you fall." Staff G stated she had told the prior Director of Nursing (DON) directly because she thought it was critical. Staff G stated the prior DON said they are working on it, we do not have a lot of Registered Nurses and Staff H is a Registered Nurse. Staff G stated she told the DON we have to do something and the prior DON responded the Administrator thinks we are picking on Staff H. During interview on 7/13/17 at 9:30 a.m. Resident #12 stated staff treated him/her good when he/she is doing right and when not doing right staff are rude. The resident stated he/she had been told, "if you fall down I am not going to pick your sorry ASS up." Resident #12 stated it was Staff H that said that to him/her. The resident stated Staff H had helped him/ her with medications and cares since making the	F 226		

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F 226	Continued From page 13 statement. Resident #12 stated she had told Staff G of the incident. During interview on 7/17/17 at 11:25 a.m. the prior Director of Nurses (DON) stated she had heard from Staff G that Staff H had made to Resident #12. The prior DON stated she thought she heard it last month, guessing, since after Resident #12's last fall on 6/18/17. The prior DON stated she had not had a chance to talk to Staff H [nearly a month later] or Resident #12 about it. The prior DON stated had not investigated the allegation and if it was valid, she knew she should report it [to the State Agency] after the investigation. This deficient practice represented a systemic failure that resulted in a determination of Immediate Jeopardy on 7/13/17 at 12:57 p.m. The facility abated the IJ on 7/13/17 when they completed the following: The Interim Administrator begun education with staff regarding the facility Abuse Program and Reporting Policy on 7/12/17. On 7/13/17, the facility started on going education with staff on the Abuse Prevention Program and Reporting policy. Staff were not allowed to work until they were educated. Staff were given a copy of the abuse policy and acknowledged a shared knowledge of understanding of what to do if there is an allegation of abuse, unkind or inconsiderate care towards a resident that they will report it to the Administrator and DON immediately. The facility provided training documentation to the State Agency (Department of Inspections and Appeals) which showed employees scheduled to work had been educated. The prior Administrator, and Staff F was	F 226		

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F 226	Continued From page 14 suspended on the evening of 7/12/17. The management staff began education staff on the Grievance Process on 7/12/17. The education provided by the management staff revealed the Administrator or designee daily will ensure prompt and appropriate follow-up in accordance with the facility's abuse and grievance policy. The facility would have departments heads meet with assigned residents on a regular basis using the Guardian Angel tool to proactively address concerns with residents as a part of the facility ongoing quality assurance process. These actions lowered the IJ from "K" severity to D with ongoing monitoring of the facility policy for reporting and investigating abuse.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	F 279		7/25/17

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F 279	Continued From page 15 comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 279		

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F 279	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure staff added psychotropic medications and adverse effects for high risk medications to resident care plans for 3 of 8 residents reviewed (Residents #2, #5 and #9). The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/23/17 identified Resident #2 with a Brief Interview for Mental Status (BIMS) score of 6, indication of severely impaired cognitive skills for daily decision making. The resident had a diagnosis of anxiety and depression. Resident #2 had received antianxiety and antidepressant medications every day in the 7 day assessment period. The CAA (Care Area Assessment) Psychotropic Drug Use Worksheet completed on 4/3/17 identified the psychotropic drug use would be covered on the care plan with the objective to avoid complications and maintain current level of function. The July 2017 Medication Administration Record (MAR) documented Resident #2 received Sertraline (an antidepressant) 125 milligrams daily with an order date of 2/23/16 and Ativan (antianxiety) 0.5 milligrams three times a day, ordered on 1/21/16. Review of the MAR 7/1/17-7/12/17 showed Resident #2 received the medications as ordered. The resident's care plan with goal date of 7/9/17	F 279		

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F 279	Continued From page 17 documented Resident #2 had diagnoses of anxiety and depression. The care plan did not record the use of the Sertraline. The care plan did not include intervention to monitor for specific adverse side effects related to the administration of Sertraline and Ativan. During an interview 7/17/17 at 1:05 p.m., the Interim Director of Nursing (DON) verified the resident's care plan lacked documentation of the use of Sertraline and to monitor for specific adverse side effects of the Sertraline and Ativan. 2. The MDS assessment dated 6/22/17 identified diagnoses for Resident #5 which included hypertension (high blood pressure), hip fracture, chronic kidney disease, localized edema (swelling) and kidney cancer. The MDS indicated the resident had a BIMs score of 14 which indicated no cognitive or memory impairment. The MDS also recorded the resident received a daily diuretic medication. Review of the MAR for July 2017 revealed Resident #5 received furosemide (a diuretic or water pill) 40 mg once a day for essential hypertension (high blood pressure). Record review of the Pharmacy Consultation Report dated 2/1/17 revealed a recommendation to add monitoring for side effects of furosemide to the resident's care plan while on furosemide due to potential electrolyte imbalance. The order signed by the physician on 3/19/17 accepted the recommendation. Record review of the care plan with a target date of 5/23/17 failed to reveal a focus or intervention for furosemide and side effects to monitor for.	F 279		

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F 279	Continued From page 18 3. The MDS assessment dated 6/29/17 identified diagnoses for Resident #9 that included heart failure, hypertension, diabetes mellitus, anxiety disorder, unspecified atrial fibrillation and other chronic pain. The MDS indicated the resident has a BIMs score of 15 which indicated no cognitive or memory impairment. The MDS also revealed the resident did not demonstrate any behaviors towards others . The MDS revealed the resident received antianxiety medication 7 days of the assessment period. Record review of the CAA revealed cognitive loss/dementia, psychosocial well-being, behavioral symptoms, activities, falls, psychotropic drug use and pain was triggered as a concern with the decision to proceed to care plan. The MAR for June 2017 documented the resident received Escitalopram Oxalate (an antidepressant)10 mg once a day, Quetiapine (antipsychotic)12.5 mg once a day and Buspirone (antianxiety) 7.5 mg two times a day for generalized anxiety disorder. The resident also received Xarelto (a blood thinning medication) 15 mg two times a day for systolic congestive heart failure. Review of the resident's care plan with a target date of 7/16/17 failed to reveal any focus or interventions for diabetes, anxiety disorder, unspecified atrial fibrillation or chronic pain. The care plan lacked medications and the side effects to monitor for. The care plan contained only 2 focus areas which included self-care performance deficit and significant weight loss.	F 279		

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F 279	Continued From page 19 An Interview with the Interim DON on 7/12/17 at 3 p.m. revealed that the care plan for Resident #9 as incomplete. The DON stated the facility usually put CAAs on care plan but she didn't have time.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to ensure services provided by the facility met professional standards for one resident receiving insulin of 11 residents reviewed (Resident #11). The facility reported a census of 36. Findings include: Findings include: 1. The Minimum Data Set assessment dated 6/19/17 noted Resident #11 had a BIMS (Brief Interview for Mental Status) score of 14, indicating intact memory and cognition. The resident had diagnoses that included diabetes mellitus and obesity. The assessment documented Resident #11 received daily insulin injections. During observation of medication pass on 7/11/17	F 281		7/20/17

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F 281	Continued From page 20 at 11:20 a.m., Staff A, LPN (Licensed Practical Nurse) drew up 2 units of Humalog Solution for Resident #11 out of a vial with a sticker showing the vial had been opened on 6/6/17. When asked how long the vial of insulin was good for after opened, Staff A stated 28 days and this is outdated. The lid of the storage bottle had date of 7/7/17 written on it. When Staff A was asked if that was the date to dispose of the vial, Staff A did not think so. Staff A then discarded the syringe and the vial of insulin and went to the medication room to get a new vial for Resident #11. Staff A stated the facility did not have another vial in the facility and she would order one from the pharmacy. Staff A did not provide the ordered medication for the resident. The July 2017 Medication Administration Record (MAR) showed Resident #11 had an order for Humalog (insulin) inject per sliding scale before meals and at bedtime. The order had a start date of 6/6/17. On 7/11/17 at 11:00 a.m. the resident blood sugar measured 179; the order directed staff to administer 2 units of insulin. The form showed documentation at 11:00 a.m. of the medication refused (see nurse notes). Review of the MAR showed the resident had received 11 doses of insulin after the vial should have been discarded on 7/7/17.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309		7/18/17 7-19-17 D.P.

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F 309	Continued From page 21 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and primary care physician interview, the facility failed to complete full assessment and delayed treatment for one of nine residents (Resident #9) reviewed. The facility identified a census of 36 residents. Findings include:	F 309		

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F 309	Continued From page 22 The Minimum Data Set (MDS) assessment dated 6/29/17 identified diagnoses for Resident #9 that included heart failure, hypertension, diabetes mellitus, anxiety disorder, unspecified atrial fibrillation and other chronic pain. According to the MDS, the resident required extensive assistance with transfers, locomotion, dressing and toilet use. The assessment revealed Resident #9 scored 15 out of 15 on the Brief Interview Mental Score (BIMS) assessment which determined no cognitive impairments. The MDS documented Resident #9 had no behaviors related to inattention, disorganized thinking or altered level of consciousness or any behaviors towards others. Review of the care plan dated 7/16/17 revealed focuses on significant weight loss and self-care performance deficit. Review of the Health Status Progress note dated 7/3/17 at 2:56 a.m. revealed Resident #9 on a skilled level of care for bowel obstruction. Staff noted the resident as alert and oriented to person, place and time. However, Resident #9 cursed several times and stared at the ceiling. The nurse asked what was wrong and the resident repeated cursing. The nurse told the resident she had his/her midnight medications and Resident #9 took his/her meds. The resident reported he/she felt okay and denied discomfort when asked. The nurse listened to the resident's lungs and bowel sounds, but did not document measurement of the resident's vital signs. An interview with Staff D, CNA (certified nursing assistant) on 7/12/17 at 1:25 p.m. revealed Resident #9 was not acting right going in and out of alertness and cursing at times during the night	F 309		

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F 309	Continued From page 23 shift of 7/3/17 around 3 a.m. Staff B, Licensed Practical Nurse (LPN) was made aware of this and checked on the resident. Staff left the resident's door open to check on them more frequently every time they went by the resident's room. An interview with Staff C, CNA on 7/12/17 at 1:26 p.m. revealed she worked night shift on 7/3/17 and observed Resident #9 being really out of it and not acting like he/she normally did. An interview with Staff B, LPN on 7/12/17 at 2:30 p.m. revealed Resident #9 acted a little different with the cursing behaviors. She stated she took the resident's blood pressure and thought it measured 104/60 (no vital signs were documented). An interview with the resident's Primary Care Physician (PCP) on 7/12/17 at 2:24 p.m. revealed he would expect a full assessment to be completed with any change in condition or behaviors including vital signs so that treatment could be sooner. Review of the Health Status Progress note dated 7/3/17 at 7:24 a.m. revealed resident with abnormal behaviors, disorientation and jerking motions. The facility sent Resident #9 to the emergency room for evaluation. Review of the History and Physical Consultation dated 7/3/17 revealed the resident presented with altered mental status. Staff noted the resident as more confused than his/her baseline and s/he did not answer questions appropriately. The initial hospital examination revealed the following concerns on arrival to the emergency department:	F 309		

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F 309	Continued From page 24 acute encephalopathy likely due to uremia, acute renal failure, hypotension and dehydration. Resident #9 admitted to hospital with diagnoses of hypotension and dehydration and required 5 Liters of oxygen.	F 309		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the resident environment remained free from accident hazards as is	F 323		7/18/17 7-19-17 D.N.

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F 323	Continued From page 25 possible by having an unlocked and unattended medication cart in a resident common area. The facility reported a census of 36 residents. Findings include: During observation on 7/12/17 at 1:56 p.m. a medication cart sat on the front side of the nurses station, across the hall from the dining room. The medication cart was unlocked and there were no staff in the area. Several residents passed by the cart as they were gathering in the dining room to play Bingo. During interview at 2:05 p.m. the Director of Nursing stated she would expect staff to lock the medication cart. The facility identified 9 of the 36 residents as cognitively impaired and able to ambulate independently.	F 323		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]	F 353		7/18/17 7-19-17 D.P.

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F 353	Continued From page 26 (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to answer resident call lights in a timely manner for 4 of 4 residents interviewed. The facility reported a census of 36 residents. Findings include: The Quality of Life Group Interview was held on	F 353		

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F 353	Continued From page 27 7/11/17 at 3:20 p.m. with four residents the facility identified as interviewable. During the interview all four residents voiced concerns with call light response times. Three of the four residents had timed staff response times. Two residents stated it took up to 45 minutes and one resident stated it took 70 minutes before staff came to their room to acknowledge the call light. During interview on 7/12/17 at 9:10 a.m. the Director of Nursing (DON) stated the facility did not have any formal call light response time audits. She stated she had spoken with staff about call lights and the need to get to them. The DON stated they have been short staffed and she knew of a resident waiting for 45 minutes on the night shift while staff were doing rounds on other residents.	F 353		
F 498 SS=E	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	F 498		7/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165238	A. BUILDING _____ B. WING _____	07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 498	Continued From page 28 (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a minimum of 12 hours of annual inservice training for the Certified Nursing Aides (CNAs). The facility reported a census of 36 residents. Findings include: Review of facility Inservice Records revealed the following areas of concern: a. Staff G, CNA attended 9 out of 12 inservices offered. b. Staff I, CNA attended 4 out of 12 inservices offered. c. Staff J, CNA attended 8 out of 12 inservices offered. d. Staff K, CNA attended 5 out of 12 inservices offered. e. Staff F, CNA attended 11 out of 12 inservices offered. f. Staff L, CNA attended 8 out of 12 inservices offered. An interview with the Interim Administrator on 7/17/17 at 3:31 p.m. revealed that there are processes in place to keep track of nursing aide education and training. She stated the Director of Nursing (DON) is responsible for this but it is not being done.	F 498		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

F157D

It is the facilities practice to notify the physician of any accident, injury, or adverse change in the resident's condition.

1. On 7/11/17 the Humalog solution for resident #11 was discarded and a new vial was ordered. On 7/12/17 the resident number 11's PCP was notified via phone and a written order was sent and returned on 7/18/17.
2. All held medications will be reviewed by the DON or designee to ensure they have been communicated with the physician. The DON or designee will also complete an audit on the medication cart to ensure there are no expired medications.
3. Staff were re-educated on 7/20/2017 that each resident primary care provider needs to be notified if a medication is not administered or held for any reason. Staff were also re-educated on 7/20/17 that expiration dates need to be double checked before the administration of any medication.
4. The DON or designee will complete daily audits on any held or non-administered medications for 2 months to ensure that any medications that are not administered or held are communicated to the resident's PCP. The DON or designee will also complete weekly audits of the medication cart to ensure there are not expired medications and medications are ordered as needed for the next two months.

F225K

It is the facilities practice to investigate/report allegations/individuals of possible abuse and immediately report allegations of abuse to the State Survey Agency.

1. Staff F, was suspended on 7/11/17 pending an investigation and terminated on 7/14/17. The facility DON was also suspended on 7/13/17 and terminated on 7/17/17.
2. The administrator and designees met with all residents on 7/13/17 to ensure there were no further concerns regarding any allegations of abuse.
3. All staff were re-educated on the facility abuse policies, procedures, and grievance process on 7/12/17. All department heads were re-educated on the facilities Guardian Angel tool on 7/12/17 to ensure all residents' concerns are proactively addressed with each resident. All residents were re-assigned and met with by a team laddered on 7/13/2017 to ensure no further concerns were outstanding. All staff were re-educated on 7/12/17 about the facilities grievance process and the difference between a grievance and abuse.
4. All resident will be interviewed daily through the facilities Guardian Angel tool to ensure prompt and appropriate follow-up. Any concerns or issues will be monitored by the facility administrator daily for three months.

F226K

It is the facilities practice to develop/implement abuse/neglect, etc. policies

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F279D

It is the facilities practice to develop a comprehensive care plan for each resident

1. On 7/14/17 residents number 2, 5, and 9's care plans were updated to ensure that all antianxiety, antidepressants, and antipsychotic are on the care plans. Residents number 2, 5, and 9's care plans were up to reflect the use and adverse side effects.
2. On 7/25/17 all residents on antianxiety, depression and antipsychotic medications had their care plans reviewed by the facilities cooperate nurse to ensure compliance.
3. On 7/13/17 the facility DON was re-educated on the need to care plan side effects for residents on depression, antianxiety, and antipsychotic medications.
4. The facility DON or designee will review care plans monthly for residents on depression, antianxiety, and antipsychotic and ensure the medications and side effects are care planned. x3 mon

F281D

It is the facilities practice to provide services that meet professional standards and direct the implementation of the physician's orders.

1. On 7/11/17 the Humalog solution for resident #11 was discarded and a new vial was ordered.
2. On 7/12/17 all residents on insulin had their medications reviewed to ensure that no other insulins were expired.
3. All nursing staff was re-educated on 7/20/17 about double checking expiration dates before the administration of any medication.
4. The DON or designee will complete weekly audits of the medication cart to ensure there are not expired medications and medications are ordered as needed for the next two months.

F309D

It is the facilities practice to provide care/services to prove for our resident's highest level of well being

1. On 7/3/2017 resident #9 was admitted to the hospital and all assessments were recorded accurately upon readmission.

2. The facility DON or designee will monitor clinical concerns and issues through the facility 24hr report and morning clinical meeting.
3. On 7/13/17 the facility DON and interim DON were re-educated on the facilities morning clinical meeting. On 7/14/17 the facility interim DON was re-educated on how to pull the facilities morning reports that addresses clinical concerns.
4. The facility DON or designee will monitor clinical concerns and issues daily for the next three months. Any concerns or issues will be addressed by the facilities QA committee.

F323E

1. It is the facilities practice to ensure that all residents are free of accidents contributed to hazards, supervision, and or devises.
2. The facility DON or designee will do random audits on the medication cart when it is unattended to ensure it is locked.
3. On 7/18/17 all nursing staff were re-educated on why we do not leave the medication cart unlocked and unattended.
4. The facility DON or designee will conduct 2 random weekly checks on the facility medication cart when it is unattended for the next two months to ensure compliance.

F353E

It is the practice of the facility to ensure that all residents have sufficient 24-hr nursing staff per care plans.

1. On 7/18/17 all residents were interviewed to address call light wait time responses.
2. On 7/15/17 weekly call light audits were implemented at the facility.
3. The 7/18/17 facilities team leaders and nursing staff were re-educated on call light wait times. On 7/13/17 the facilities team leaders were also re-educated on the facilities Guardian Angel program that addresses call light wait times and acceptable call light wait times.
4. The facility Administrator or designee will complete monthly call light wait time audits for the next three months to ensure compliance. Any concerns or issues will be monitored through the facilities QA process.

F498E

It is the practice of the facility to ensure that nurse aides demonstrate competency when providing care for all residents.

1. On 7/18/17 all CAN's were re-educated on the facilities expectation regarding employee in-services.
2. On 7/19/17 a new system was created to monitor the attendance of each CNA and will be up dated at each in-service.
3. All department leaders and staff were re-educated on the facilities expectations and requirements regarding staff in-services. All team leaders were re-educated on how the new system works and where the documentation should be kept.
4. The facility administrator or designee will complete monthly audits on the new employee in-services system to ensure that all in-services are being offered and all required employees

attend or make up the required in-services. The facility administrator or designee will complete monthly audits for the next three months. Any concerns or issues will be monitored through the facilities QA process.

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