STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 2/26/17 The following deficiencies were identified during the facility's annual survey and investigation conducted 1/23/17 to 1/26/17. Investigation of facility-reported incident # 65425-I resulted in deficiency. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rebecca S. Maddalozzo, RN, Administrator 2/20/17

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.

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F 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and	F 156		

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F 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

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F 156	Continued From page 3 and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 156		

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156		

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F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to adequately inform 1 of 3 residents reviewed of their appeal rights following discharge from skilled services, (Resident #26). The facility reported a census of 96 residents. Findings include:	F 156		

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F 156	Continued From page 6 1. Facility records indicated Resident #26 received Medicare Skilled Services 1/10/17 to 1/15/17. The resident's record lacked documentation the facility issued a Notice of Medicare Provider Non-Coverage form (CMS, Centers for Medicare and Medicaid Services, 10123) and a Skilled Nursing Facility Advanced Beneficiary Notice form, CMS-10055, or one of the five uniform denial notices. During interview 1/25/17 at 12:10 p.m. the Nurse Consultant verified Resident #26's record lacked documentation the notices issued prior to the resident's discharge from Medicare Part A services.	F 156		
F 226 SS=D	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 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also	F 226		

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F 226	Continued From page 7 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 review of 13 personnel files and staff interviews, the facility failed to ensure Staff E received the proper mandatory reporter training and failed to obtain approval from the Iowa Department of Human Services when a person had a criminal history record, prior to hiring Staff D. The sample consisted of 13 new employee files reviewed. The facility reported a census of 96 residents. Findings included: 1. The personnel file for Staff D (nursing) identified a SING (Single Contact License and Background Check) form, dated 7/25/16, directed the facility that further research was needed and to wait for the DCI (Department of Criminal Investigations). A DCI report, dated 7/27/16, revealed Staff D's criminal history record attached. The personnel record identified Staff D had a date of hire of 8/22/16. Staff D's personnel file lacked documentation the facility received approval from DHS (Department of Human Services) that Staff	F 226		

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F 226	Continued From page 8 D was eligible to be hired at the facility. During an interview on 1/25/17 at 12:15 p.m., the Nurse Consultant verified the facility had not submitted the paper work to DHS prior to hire to find out whether or not Staff D had been eligible for employment. 2. The personnel file for Staff E, Licensed Practical Nurse, had a date of hire as 3/21/16. Staff E's personnel file had a certification of completion for attending a 3 hour course titled Mandatory Reporter: Child and Dependent Adult Abuse on 10/2/14. During an interview 1/25/17 at 12:15 p.m., the Nurse Consultant verified Staff E had not completed the correct mandatory reporter training.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to treat one resident with dignity and consideration for their preferences regarding their care for 1 of 17 current resident reviewed (Resident #15). The facility reported a census of 96 residents. Findings included:	F 241		

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F 241	Continued From page 9 Resident #15's 10/23/16 Minimum Data Set (MDS) assessment documented the resident had a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired memory and cognition. The resident required extensive assistance of 2 staff for transfers and did not walk. The assessment documented his/her diagnoses included anxiety and Down syndrome. The resident's Care Plan, revised on 5/9/16, directed staff to assist the resident with transfers in an EZ Stand mechanical lift with assistance of 2 staff. The Care Plan also stated the resident had impaired cognition and slurred speech due to Downs syndrome. The resident also had a hard time with appropriate coping skills and sensitivity to having his/her feelings hurt. The Care Plan noted the resident became easily frustrated and became agitated. The resident often cried when he/she didn't like something. During observation on 1/25/17 at 12:14 p.m. the resident laid in bed. Staff J and Staff K, Certified Nursing Assistants (CNAs) assisted the resident with incontinence care and told the resident they were going to get him/her up for the noon meal. The CNAs had brought the mechanical sling lift into the room. The resident said he/she didn't want to use the sling lift. The resident began crying, stated he/she was scared and "please". The CNAs told the resident they always used the sling lift. The resident continued to repeat over and over "I'm scared". Staff K told the resident the doctor had said they had to use it. When asked more about it Staff K stated they only used the sling lift to get the resident out of bed and used the EZ stand for all other transfers. Staff K stated they used it because the resident had a sore on his/her bottom. Staff K added the sling lift	F 241		

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F 241	Continued From page 10 scared the resident and they resident always cried when they used it. The resident continued to cry and stated s/he was scared all during incontinence care that staff provided. The CNAs stated nurses told them to use the sling lift but neither could recall which nurse had directed that. Staff K stated she didn't think it was right they had to make the resident do it when s/he doesn't like it. The resident continued to cry, stated s/he was scared repeatedly as staff placed the sling under him/her. During interview on 1/25/17 at 2:33 p.m. the Director of Nursing stated if they resident became upset staff should tell the nurse and explore other options. Review of the resident's clinical record revealed no documentation indicating any plan for staff to use the sling lift or any documentation indicating staff had discussed use of the sling lift with the resident or explored any other options.	F 241		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 252		

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F 252	Continued From page 11 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a homelike, well-maintained, and sanitary environment for residents in the facility. The facility reported a census of 96 residents. Findings included: 1. Environmental observation on 1/23/17 at 11:33 a.m. revealed the following concerns: a. An Environmental Services door at the beginning of Ficus (F) hall had marring and scratches with some of the wood bare and staff unable to sanitize the door. One of the fire doors at the entrance to F hall had marring and felt rough to touch on the lower 1/3 of the door. b. The wooden hand rails to the east and west of the main entrance, Aspen (A) hall, the hall between A and Bayberry (B) halls, B hall, and Cherry Blossom (C) hall, had several scratches that exposed bare wood. c. Aspen hall, resident room A3, had an closet door with a 1 inch by 2 inches area at the bottom that was gouged and the edges sharp to touch. The inside of the hall door of rooms A3 and A4 had a marred area 3/4 inch wide by 15 inches long that had bare wood and staff unable to sanitize. Resident room A7 had a 4 drawer chest	F 252		

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F 252	Continued From page 12 with scratched/marred bare wood on the side of the chest at the bottom. d. C hall had a fire door by resident room C-2 that was marred and had bare wood. The fire door on the spa room side had an open edge with bare wood from top to bottom and the edge of the door felt rough to touch at the bottom. e. Resident room C-5 door on the hall side had bare marred wood that measured 1 1/2 inches wide by 4 feet long. The lower 3 feet of the inside door frame had a large amount of chipped paint. The wall near the floor by a closet had a hole that measured approximately 2 inches wide by 3 inches high. A 4 drawer chest had top and bottom drawers that had a large amount of marring and several scratches. 2. Observation during environmental tour with the Maintenance Manager and the Nurse Consultant 1/25/17 at 1:00 p.m., revealed the open edge of the E hall spa door had bare wood and the area as rough to touch. The staff verified the concerns with the wood work and hand rails. The Maintenance Manager stated the facility owners want to replace the current hand rails with vinyl hand rails but they had no current plan in place.	F 252		
F 279 SS=E	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.	F 279		

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F 279	Continued From page 13 483.21 (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 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.	F 279		

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 279	Continued From page 14 (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. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to update care plans for the use of psychotropic medications (used for psychiatric conditions) and anticoagulant medication in regards to side effects or risks involved with their use for 4 of 17 current residents reviewed (Residents #2, #3, #8 and #12). The facility reported a census of 96 residents. Findings include: 1. According to a diagnosis sheet form dated 1/24/17, Resident #2's diagnoses included anxiety disorder and major depressive disorder. A Physician's Order form dated 8/11/16, included orders for Haldol (anti-psychotic medication) 0.5 milligrams (mg) at bedtime and quetiapine (Seroquel -anti-psychotic medication) 12.5 mg., 2 times a day. A Medication Review Report form dated 1/24/17 revealed the resident received the Haldol for his/her anxiety disorder and the quetiapine for	F 279		

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F 279	Continued From page 15 his/her depressive disorder. A Physician's Telephone Orders dated 6/12/15, revealed the start date of the resident's Haldol medication. A facsimile from the resident's physician dated 4/10/15, revealed the start date of the resident's quetiapine medication. A Care Area Assessment (CAA) worksheet with an assessment reference date of 6/19/16 documented Resident #2 triggered for psychotropic drug use with a plan to for the drug use to be addressed on the resident's care plan. Resident #2's care plan with a print date of 1/23/17 lacked reference or intervention for the use of psychotropic medications. 2. According to a diagnosis sheet form dated 1/24/17, Resident #3's diagnoses included severe intellectual disabilities. A Physician's Order form dated 8/11/16, included orders for quetiapine 12.5 mg every noon and 25 mg every evening. The orders identified a diagnosis for use of the medication as severe intellectual disabilities. A History and Physical Report form dated 11/16/11, identified orders for quetiapine 50 mg, 3 times a day. (note- the resident had received quetiapine for at least 5 years). A CAA worksheet with an assessment reference date of 4/24/16, documented Resident #3 triggered for psychotropic drug use with a plan for the drug use to be addressed on the resident's	F 279		

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F 279	Continued From page 16 care plan. Resident #3's care plan with a print date of 1/23/17 lacked reference or intervention for the use of psychotropic medications. During interview on 1/25/17 at 4:00 P.M., the facility's Director of Nursing (DON) confirmed psychotropic medication use needed to be addressed on a residents care plan. Findings included: 3. Resident #10's Medication Administration Record (MAR) documented diagnoses including but not limited to depression. The resident received Escitalopram, an antidepressant medication, 10 milligrams (mg.) daily. The resident also received Coumadin, an anticoagulant medication, 6 mg. daily on Mondays and Fridays and 5 mg. all other days. During interview on 1/25/17 at 2:33 p.m. the Director of Nursing stated the resident used the Coumadin related to an implanted cardiac pacemaker. The resident's 11/25/16 Care Area Assessment (CAA) stated a plan to address the resident's antidepressant medication use on the care plan to maintain the resident's current level of functioning and provide symptom relief or palliative measures. The resident's Care Plan lacked any mention of the depression diagnosis, the use of antidepressant medication or possible side effects of the medication. The Care Plan further lacked any mention of the resident's pacemaker or the use of Coumadin or possible side effects	F 279		

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F 279	Continued From page 17 related to use of that medication. During interview on 1/25/17 at 3:55 p.m. the DON stated she expected staff to address psychoactive medications and anticoagulant medications on the Care Plan. 3. According to the MDS assessment dated 11/18/16 Resident #8 had diagnoses that included pneumonia and respiratory failure. The MDS documented a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognitive skills. According to the MDS, the resident required total dependence on 2 or more persons with transfers, bed mobility, toileting and bathing. The MDS documented that walking in the room or corridor did not occur. Review of a Care Area Assessment (CAA) worksheet dated 1/25/17 revealed problems or conditions of changing cognitive status, pneumonia, pain, psychoactive medications, mood decline, falls, recent hospitalization and physical limitations. Review of a Mediacation Administration Record (MAR) dated 1/1/17-1/31/17 revealed the resident received: a. Bupropion ER (antidepressant/anxiety medication) 150 milligram (mg) daily b. Seroquel (antipsychotic medication) 25 mg -1/2 tablet at bedtime c. Warfarin (anticoagulant medication) 6 mg daily d. Seroquel 25 mg every 6 hours as needed for agitation Review of the care plan dated on 11/14/16 revealed the care plan failed to address anticoagulant and psychotropic medications with side effects.	F 279		

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F 279	Continued From page 18 4. According to the MDS assessment dated 1/5/17 Resident #12 had diagnoses that included urinary tract infection and an elevated white blood count. The MDS documented a BIMS score of 7 indicating severely impaired cognitive skills. According to the MDS, the resident required extensive dependence on 2 or more persons with transfers and toileting. Review of a CAA worksheet dated 1/5/17 revealed a problem with an antidepressant medication with possible adverse consequence for increased risk for falls. Review of the MAR dated 1/1/17-1/31/17 revealed the resident received: Fluoxetine (antidepressant) 10 mg daily Review of the resident's Care Plan dated 12/29/16 revealed it failed to address psychotropic medications with side effects for staff to watch for.	F 279		
F 281 SS=B	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, the facility failed to complete physician orders to weigh residents for 2 of 17 current residents reviewed (Residents #10 and #15). The facility identified a census of 96 current residents.	F 281		

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F 281	Continued From page 19 Findings included: 1. According to the Minimum Data Set (MDS) assessment dated 12/15/16, Resident #10 had diagnoses that included peripheral vascular disease and diabetes. Resident #10's 1/3/17 nursing Progress Notes documented at 11:02 a.m. the resident had increased shortness of breath. Staff noted the resident's abdomen as distended and tight and documented the residents' weight had increased from 298# (pounds) on 12/28/16 to 313# on 1/3/17. Staff made an appointment with the physician. The physician ordered medication changes and directed staff to obtain daily weights. According to the resident's Weights and Vitals summary record, staff failed to weigh the resident on 1/6/17, 1/9/17, 1/14/17, 1/15/17, 1/20/17 and 1/23/17. 2. Resident #15's Medical Diagnosis List dated 1/25/17 documented his/her diagnoses included heart failure and obesity. A 10/27/16 Physician's Progress Note documented additional diagnoses of chronic kidney disease Stage III. The resident's Physician's Orders dated 11/29/16 directed staff to weigh the resident weekly. The resident's 1/17 Medication Administration Record documented staff weighed only once from 1/1/17 to 1/25/17, on 1/13/17, not weekly as ordered.	F 281		
F 282	483.21(b)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 20 PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations, the facility failed to follow the care plan for 2 of 17 current residents reviewed (Resident #7 and #10). The facility reported a census of 96 residents. Findings included: 1. Resident #10's 12/15/16 Minimum Data Set (MDS) documented the resident had no impairment of cognitive function. The resident required extensive assistance of staff with transfers and ambulation. The resident's Care Plan included a problem of fall prevention noting the resident at risk for falls related to a history of falls, medication side effects, and weakness. The Care Plan directed staff to walk the resident 50 feet with assistance of 1 staff and a front wheeled walker 3 times daily. The record lacked any documentation indicating staff assisted the resident with ambulation. During interview on 1/25/17 at 10:27 a.m. the resident stated staff no longer assisted him/her with ambulation. The resident stated he/she had not been assisted with ambulation since Physical Therapy had been discontinued.	F 282		

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F 282	Continued From page 21 During interview on 1/25/17 at 10:49 a.m. the Director of Nursing (DON) stated no documentation could be found indicating staff had assisted the resident with the ambulation program. 2. According to the MDS assessment dated 11/4/16, Resident #7 scored 2 on the Brief Interview for Mental Status (BIMS) test, indicating severe memory and cognitive impairment. Resident #2 required the assistance with dressing. The resident's Care Plan, dated 11/16/17 and revised 1/15/17, identified Resident #7 with areas on his/her heels on 11/15/16. The left heel healed on 12/28/16 and he/she had a pressure ulcer to the right heel. The interventions included offloading boots to both feet at all times. Resident #7 liked to take them off so encourage the resident to continue to wear them. During an observation on 1/24/17 at 7:30 a.m. Resident #7 sat in the lounge area with a gray (offloading) boot on the right foot and a slipper on the left foot. At 8:55 a.m., 9:20 a.m., 10:20 a.m., 11:00 a.m. and 11:25 a.m., Resident #7 continued to wear a slipper to the left foot. At 12:12 p.m. observation revealed a heel boot on Resident #7's bed. At 12:30 p.m. and 1:43 p.m. Resident #7 continued to wear a slipper on their left foot. At 2:22 p.m. staff transferred Resident #7 to bed and provided care. Staff put heel boots on both feet. Staff H Certified Nursing Assistant (CNA) and Staff S CNA stated Resident #7 only wore the left boot in bed. During an interview on 1/25/17 at 3:58 p.m. the	F 282		

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F 282	Continued From page 22 DON stated she expected staff to follow the care plan.	F 282		
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F 285		

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F 285	Continued From page 23 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 285		

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F 285	Continued From page 24 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and observation, the facility failed to provide services as recommended according to a Preadmission Screening and Resident Review (PASRR) form for 3 of 4 residents reviewed for PASRR services (Residents #9, #21, and #22). The facility reported a census of 96 residents.	F 285		

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F 285	Continued From page 25 Findings included: 1. A Minimum Data Set (MDS) assessment dated 12/16/16 documented that Resident #9's diagnoses included anxiety disorder and depression. The MDS identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact memory and cognition. The assessment also documented the resident had trouble with sleep more than half of the days of the assessment period and had little interest or pleasure in doing things during several days of the assessment period. Review of a History and Physical form dated 1/8/16 revealed a Medical Provider documented the resident presented to a emergency room with complaints of a panic attack and hallucinations and delusions. An After Visit Summary form, with a facsimile date of 1/25/16, revealed the resident required hospitalization on a behavioral health unit between the dates of 1/9 - 1/25/16. The form recorded the resident discharged to the facility with instructions for the resident's need to see a psychiatrist at the facility along with a notation the facility Director of Nursing (DON) being notified of the need for the resident to see a psychiatrist. A PASRR form with a determination date of 1/25/16, identified the resident with a mental illness and included the following recommended psychiatric services, a behaviorally based treatment plan, community living skills, education regarding medication compliance and socialization/leisure/recreational activities.	F 285		

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F 285	Continued From page 26 Resident #9's Care Plan with a print date of 1/23/17 lacked any plan for the resident to receive services as recommended according to the PASRR screening regarding psychiatric services, behavioral based treatment plan, community living, medication education or socialization skills. During interview on 1/24/17 at 9:05 A.M., the Interim DON (Director of Nursing) confirmed the resident's record lacked a plan of care related to the PASRR recommendations and she could not find an Psychiatric notes in the resident's record. During interview on 1/24/17 at 12 P.M., the facility's Corporate Nurse stated Resident #9 had not seen a psychiatrist since returning from the hospital on 1/25/16. 2. The MDS assessment dated 11/28/16 documented that Resident #21's diagnoses included Non-Alzheimer's dementia, Parkinson's disease, depression, amyotrophic lateral sclerosis and mild cognitive impairment. The MDS identified the resident's with problems with short and long term memory and severely impaired cognitive skills for daily decision making. The assessment also documented the resident experienced fluctuating inattention and disorganized thinking. Review of the resident's PASRR dated 6/5/15 revealed recommendations for psychiatric services by a psychiatrist to evaluate response to psychotropic medications, modify medication orders and to evaluate response to need for ancillary therapy services. The PASRR also documented diagnoses of major depressive disorder/recurrent and severe with psychotic	F 285		

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F 285	Continued From page 27 features and dementia not otherwise specified. The resident's Care Plan dated 1/10/17 failed to document PASRR recommendations or interventions. Review of the resident's clinical record revealed no progress notes from a psychiatrist. Review of a medication administration record (MAR) dated January 1-31, 2017 reveal the following psychotropic medications administered: a. Sertraline (antidepressant medication) 50 milligrams (mg) daily with start date of 9/16/16 b. Trazodone (antidepressant/sleep medication) 100 mg daily with a start date of 9/20/16 c. Lorazepam (anti-anxiety medication) 0.5 mg twice daily with a start date of 9/20/16 d. Risperidone (antipsychotic medication) 0.5 mg twice daily with start date 9/20/16. During a interview with Staff U, Registered Nurse (RN) on 1/25/17 at 10:34 AM, he stated all he could find in the clinical record was the medication monthly review. He could not locate medication management by a psychiatrist in the record. 3. The MDS assessment dated 1/07/17 documented that Resident #22's diagnoses included Non-Alzheimer's dementia, Alzheimer's disease, anxiety disorder, depression and Downs syndrome. The MDS identified the resident with a BIMS score of 0 indicating severe memory and cognitive impairment. The assessment also documented the resident experienced fluctuating inattention and disorganized thinking. Review of the resident's record on 1/24/17 at 10:15 AM failed to reveal a PASRR in the record.	F 285		

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F 285	Continued From page 28 Staff U stated at this time he would look for it. Staff U later brought the PASRR. Review of the resident's PASRR dated 9/30/16 revealed recommendations for initial psychiatric evaluation to determine diagnoses as the resident experienced new mental health symptoms and to develop a plan of care. The PASRR also recommended the development of a crisis intervention/safety plan in the event the resident's symptoms escalate. The PASRR also documented diagnoses of moderate intellectual disability and dementia not otherwise specified. Review of the resident's Care Plan dated 12/26/16 failed to document the PASRR recommendations, interventions or crisis intervention/safety plan. Review of the record failed to document any progress notes from a psychiatrist. Review of the resident's MAR dated January 1-31, 2017 revealed the following psychotropic medications administered: a. Celexa (antidepressant medication) 20 mg daily with a start date of 10/1/16 b. Haloperidol (antipsychotic medication) 1 mg twice daily with a start date of 10/8/16 c. Lorazepam 0.5 mg twice daily with a start date of 11/23/16 d. Lorazepam 0.5 mg every 8 hours as needed for agitation with a start date of 9/30/16 Observation on 1/24/17 at 12:10 revealed the resident screaming and hollering in the north dining nook.	F 285		
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309		

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F 309 SS=D	Continued From page 29 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 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (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 and staff interview the facility failed to assess and intervene for 1 of 17 current residents reviewed who experienced constipation (Resident#4) and also failed to assess and intervene for 1 of 1 sampled resident who experienced swallowing problems (Resident #15). The facility reported a census of 96 residents. Findings included:	F 309		

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F 309	Continued From page 30 1. Resident #4's 11/11/16 Minimum Data Set (MDS) assessment documented the resident had a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired memory and cognition. The assessment documented s/he needed the assistance of one with toilet use and did not experience constipation during the assessment time period. The resident's January 2017 Medication Administration Record (MAR) documented an order for Milk of Magnesia and Bisac-Evac suppository as needed for constipation. Staff documented on the resident's Bowel Movement record the resident had a small bowel movement on 1/14/17 at 1:59 p.m. Staff documented the resident had no further bowel movements until 6 days later on 1/22/17 when they documented the resident had a bowel movement at 8:58 p.m. Staff documented on the MAR administration of Milk of Magnesia on 1/22/17 at 6:56 a.m., but lacked any documentation staff administered either the laxative or the suppository prior to that date. During interview on 1/24/17 at 1:21 p.m. the Director of Nursing stated they had no protocol for how to treat residents with constipation. At 2:36 p.m. she stated she would expect after 3 days without a resident bowel movement, staff should offer a laxative or a suppository or contact the doctor to get an order for laxative. 2. Resident #15's 10/23/16 MDS documented the resident had a BIMS score of 5, indicating severely impaired memory and cognition. The	F 309		

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F 309	Continued From page 31 assessment documented s/he required supervision and set up assistance for meals. Nursing Progress Notes dated 1/3/17 at 10:58 a.m. recorded the resident began choking at breakfast. The resident cleared the obstruction by coughing it up. The resident's clinical record lacked any documentation indicating what the resident had coughed up or the volume of the substance expelled. After breakfast, the notes recorded that Resident #10 had a small emesis and occasional moist cough. Staff noted their lung sounds as clear and notified the physician. Staff documented at 12:44 p.m. the resident had clear liquids for lunch and had another emesis after eating. On the same date at 2:45 p.m. staff measured the resident's temperature at 98.3 degrees Fahrenheit. Staff noted the resident coughing and with a small emesis. The record lacked any documentation indicating the nature or volume of the emesis. At 5:10 p.m. staff measured the resident's temperature 101.9 F and administered Acetaminophen. At 7:20 p.m. staff documented the resident's temperature at 99.5 F. At 9: 15 staff documented the resident's temperature as 100.8 F. At 10:30 p.m. staff documented the resident had an occasional hacking cough through the shift and noted the lung sounds clear. On 1/10/17 staff documented in the nursing Progress Notes they had faxed the resident's physician requesting a speech evaluation and treatment per therapy recommendations due to noting the resident coughing with meals. The record lacked any documentation describing the nature or frequency of the resident's coughing or if the resident expelled any sputum with the coughing after 1/3/17.	F 309		

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F 309	Continued From page 32 On 1/16/17 at 1:37 p.m. the Dietitian noted in the Progress Notes the physician had been faxed on 1/10/17 requesting a speech evaluation due to coughing at meals. The dietitian noted a plan to follow up on the speech evaluation. Review on 1/25/17 revealed the resident's record lacked any documentation indicating the physician had responded to the request or that any staff had followed up with the physician in regard to the request. The record lacked any documentation indicating staff initiated monitoring for choking when eating. During interview on 1/25/17 at 2:11 p.m. Staff B, Registered Nurse, Unit Manager provided a fax dated 1/25/17 requesting an order for the speech evaluation. She stated no other follow up or notifications to the physician could be found.	F 309		
F 317 SS=D	483.25(c)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE (c) Mobility. (1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to provide Restorative Nursing Programs for 2 of 11 sampled residents with limitations in functional range of motion (Residents #4 and #6). The facility reported a	F 317		

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F 317	Continued From page 33 census of 96 residents. Findings included: 1. Resident #4's 8/14/16 Minimum Data Set (MDS) assessment documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating memory and cognitive impairment. The resident required the assistance of one with transfers and walking. Staff documented the resident had no limitations in functional range of motion (ROM). The resident's 11/11/16 MDS documented the resident required the assistance of one staff with transfers and ambulation. The assessment documented the resident now had limitations in functional ROM in both lower extremities. A Physical Therapy Discharge Summary documented the resident had received skilled Physical Therapy (PT) services from 12/22/15 - 3/17/16. The Summary documented Discharge Recommendations that included a Functional Maintenance Program/Restorative Nursing Program and Assistive device for safe functional mobility and to facilitate the resident in maintaining his/her current level of performance and in order to prevent decline. PT staff noted development of a Restorative Nursing Program and staff instruction on the program as completed with the interdisciplinary team related to ambulation and transfers. An Occupational Therapy Discharge Summary documented the resident received OT services from 12/4/15 to 3/14/16. The Occupational Therapist made discharge recommendations including a Functional Maintenance	F 317		

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F 317	Continued From page 34 Program/Restorative Nursing Program to be established upon the resident's discharge from Physical Therapy services. During interview on 1/24/17 at 10:08 a.m. Staff M, Licensed Practical Nurse (LPN) stated documentation of restorative programs would be found in the electronic record. Review of the resident's electronic record revealed no documentation of any restorative program. During interview on 1/24/17 at 10:14 a.m. Staff B, Registered Nurse stated they kept resident Restorative programs in a book. She provided the book and no program for Resident #4 could be found. During interview on 1/25/17 at 10:01 a.m. the Director of Nursing (DON) stated the resident had never had a Restorative Nursing or Functional Maintenance Program. 2. Resident #6's 3/27/16 MDS documented the resident had a BIMS score of 3. The resident required extensive assistance of 2 staff for transfers and did not ambulate. Staff documented the resident had no limitations in functional ROM. The resident's 12/9/16 MDS documented the resident continued to require extensive assistance of 2 staff for transfers and did not ambulate but now documented the resident had limitations in ROM of both lower extremities. The electronic record lacked any documentation indicating staff assisted the resident with any restorative or functional maintenance programs. The book which held residents' restorative programs lacked any program for Resident #6.	F 317		

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F 317	Continued From page 35 During interview on 1/24/17 at 10:01 a.m. the DON stated no documentation could be found to indicate staff had ever assisted the resident with a restorative or functional maintenance program. She agreed residents with limitations in functional ROM should be provided such programs.	F 317		
F 323 SS=D	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 clinical record review and staff	F 323		

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F 323	Continued From page 36	F 323		

interview, the facility failed to prevent resident to resident altercation for Residents #5 and #6 and failed to provide adequate supervision to prevent accidents for one resident (Resident #8) out of a total of 17 current residents sampled. The facility reported a census of 96 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 12/16/16, Resident #5 scored 10 on the Brief Interview for Mental Status (BIMS) test indicating moderate memory and cognitive impairment. Resident #10's diagnoses included a psychotic disorder. The assessment documented that Resident #5 had no behavioral symptoms directed towards others during the assessment period.

An Internal Investigation Form dated 6/17/16 at 3:50 p.m. documented that Resident #5 hit another resident with the back of his/her hand to the other resident's upper back when the other resident bumped Resident #5's wheelchair in passing. The residents were immediately separated.

The resident's Care Plan, revised on 7/29/16, identified Resident #5 sometimes became angry enough to be physically aggressive toward others. The interventions included frequent checks initiated 6/17/16 and resolved on 1/19/17, redirection when voicing a concern/problem that they already addressed, talk slowly when not able to understand, offer kind words and reassurance when upset, and allow Resident #5 to vent their feelings. The Care Plan did not address Resident #5's history of hitting another resident or how to keep other residents safe when he/she became

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F 323	Continued From page 37 upset. An Incident Progress Note dated 1/19/17 at 4:11 p.m. documented Resident #5 hit another resident in the wrist area while in the dining room. The residents were immediately separated and staff started 1 to 1 (checks) during waking hours and frequent checks during sleep hours. The family and the physician were notified. Staff also called the psychiatric provider because he managed Resident #5's psychiatric medications. During an interview on 1/24/17 at 12:17 p.m. Staff T Certified Nursing Assistant (CNA) stated she worked 1/19/17 and witnessed Resident #5 hit Resident #6. Staff T stated toward the end of lunch she helped clean the dining room. She said Resident #5 had been going in and out of the dining room hollering, upset about his/her roommate or something. After going in and out of the dining room several times, Resident #5 went to the table where Resident #6 sat with another resident. Resident #5 continued hollering and Resident #6 tapped his/her arm trying to get his/her attention. Resident #5 slapped Resident #6's wrist with an open hand. Staff T saw and heard the slap. Staff T immediately removed Resident #6 from the area and took him/her to a nurse. Staff T had heard Resident #5 yelling and upset before, but did not know the resident had a history of hitting another resident. She stated she worked as needed and did not know what Resident #5's care plan contained. 2. According to the MDS assessment dated 11/18/16 Resident #8 had diagnoses that included pneumonia and respiratory failure. The MDS documented a BIMS score of 14 indicating	F 323		

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F 323	Continued From page 38 intact memory and cognitive skills. According to the MDS, the resident required total dependence on 2 or more persons with transfers, bed mobility, toilet use and bathing. The resident had impaired balance with surface-to-surface transfers and could not stabilize only with assistance. The MDS documented one fall without injury during the assessment period. A Fall Risk Assessment tool dated 11/11/16 revealed a score of 9. The risk assessment tool projected that a score of 10 indicated a risk of falling. Review of a Progress Note dated 11/13/16 at 7:06 PM revealed that the resident had a fall. A dietary aide found the resident in front of the recliner while delivering a tray. The progress note documented the recliner was all the way in the sitting position. The progress note documented there were no injuries. The resident's Incident Report dated 11/13/16 revealed the intervention to prevent further falls was to remove the recliner. Review of a Progress Note (NEW) dated 11/13/16 at 3:14 PM revealed a change made to the current treatment plan by nursing was to remove the recliner from the room. Review of the care plan dated 11/13/16 revealed a focus on the risk for falls related to weakness, confusion at times, resident's belief he/she was capable of doing more than able at this time, medication side effects and post cerebrovascular accident. The care plan indicated when reviewed on 1/23/17 revealed the recliner was removed from the room.	F 323		

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F 323	Continued From page 39 Review of a Progress Note dated 1/23/17 at 18:30 (6:30 PM) revealed the resident found lying on the floor next to the recliner. The resident denied hitting his/her/head. The resident stated they were trying to adjust the way they were sitting and slid out of the chair. The note documented there were no injuries. Review of a Fall Report dated 1/23/17 at 6:59 PM revealed no additional interventions. Observation on 1/24/17 at 7:13 AM revealed the resident resting in bed. Further observation revealed a recliner placed at the foot of the bed. Observation on 1/25/17 at 1:23 PM revealed the resident seated in the recliner wearing slippers with a pillow behind his/her back. During an interview with the Director of Nursing (DON) on 1/26/17 at 8:10 AM, she stated the staff had replaced the electric recliner with a manual recliner after the first fall on 11/13/16. The DON stated the intervention was not changed on the care plan. The DON stated the recliner being removed from the room was deleted from the care plan this morning by Staff U, registered nurse (RN). The DON stated there were no additional interventions initiated.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		

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F 329	Continued From page 40 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interview, the facility failed to review psychotropic medications (for psychiatric conditions) used for excessive duration without attempting a gradual dose reduction (GDR) and/or failed to document a clinical contraindication for the lack of a GDR, for 2 of 11 current residents reviewed who received psychotropic medications (Resident #2 and #3). The facility reported a census of 96 current residents. Findings included: 1. According to a diagnosis sheet form dated 1/24/17, Resident #2's diagnoses included anxiety disorder and major depressive disorder. Review of the resident's Minimum Data Set (MDS) assessment dated 11/25/16 revealed the resident had no indicators of psychosis, exhibited no verbal or physical aggressive behaviors and	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 41 lacked indication or appearance of feeling down, depressed or hopeless. The assessment documented the resident experienced fluctuating inattention and disorganized thinking. A Physician's Order form dated 8/11/17 included orders for Haldol (anti-psychotic medication) 0.5 milligrams (mg) at bedtime and quetiapine (Seroquel -anti-psychotic medication) 12.5 mg., 2 times a day. A Medication Review Report form dated 1/24/16 revealed the resident received the Haldol for his/her anxiety disorder and the quetiapine for his/her depressive disorder. A Physician's Telephone Orders dated 6/12/15 revealed the start date of the resident's Haldol medication. A facsimile from the resident's physician dated 4/10/15 recorded the start date of the resident's quetiapine medication. Review of Physician progress notes dated 2/11/16, 6/2/16, 9/22/16 and 11/17/16 lacked documentation of the resident experiencing signs or symptoms of psychosis, anxiety or depression. Review of Social Service progress notes dated 4/13/16, 7/7/16, 9/15/16 and 12/8/16 lacked documentation in regards to the resident experiencing signs/symptoms of psychosis, anxiety or depression. Review of Nurses progress notes between the dates of 6/1/16 - 1/25/17 lacked documentation in regards to the resident experiencing any signs/symptoms of psychosis, anxiety or	F 329		

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F 329	Continued From page 42 depression, Review of a Note To Attending Physician/Prescriber note, with a medical review date of 4/21/16, revealed a pharmacist requested the resident's PRN (whenever necessary) Haldol medication be discontinued due to lack of use. The physician discontinued the PRN Haldol. Review of a Consultation report form dated 11/16/16 revealed a pharmacist documented the resident received 2 or more medications (Haldol for anxiety and Seroquel for depression) and requested the physician consider a GDR of Haldol or a clinical rationale if no changes. A Nurse progress noted dated 11/23/16, revealed staff received a facsimile back from the resident's physician in regards to a GDR of Haldol and noted the physician would address the medication at the next nursing home visit. Record review as of 1/24/17, revealed no documentation in regards to a physician visit or review of Haldol for a GDR. Record review revealed the last request for a GDR of quetiapine from a pharmacist to the resident's Physician had been completed 6/30/2015 (1 and 1/2 years prior). A www.pdr.net/drug-summary website (pdr-Physician's Desk Reference) included the following information in regards to Haldol use in geriatric persons: For the treatment of schizophrenia, the treatment of symptoms associated with Tourette's syndrome, acute mania and the treatment of severe behavioral disturbances such as agitation,	F 329		

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F 329	Continued From page 43 aggression and psychosis due to cognitive impairment. The pdr website's boxed warning for antipsychotics included the following information: Anti-psychotics such as Haldol are not being approved by the food and drug administration (FDA) for the treatment of dementia-related psychosis in geriatric patients. The FDA considered elderly patients with dementia related psychosis, to be at an increased risk for death when treated with anti-psychotic medications. A www.pdr.net/drug-summary website included the following information in regards to quetiapine use in geriatric persons: For the treatment of major depression, bipolar disorder, schizophrenia and the treatment of severe behavioral disturbances such as agitation, aggression and psychosis due to dementia in elderly patients. 2. According to a diagnosis sheet form dated 1/24/17, Resident #3's diagnoses included severe intellectual disabilities. The resident's MDS assessment dated 12/30/16 revealed s/he had no indicators of psychosis and no verbal or physical aggressive behaviors. A Physician's Order form dated 8/11/16, included orders for quetiapine 12.5 mg every noon and 25 mg every evening. The orders identified a diagnosis for use of the medication as severe intellectual disabilities. A Medication Review Report form dated 1/24/17, revealed indications for use of the quetiapine medication continued to be due to severe	F 329		

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F 329	Continued From page 44 intellectual disabilities. A History and Physical Report form dated 11/16/11, identified orders for quetiapine 50 mg, 3 times a day (note- the resident had received quetiapine for at least 5 years). Review of Physician progress notes dated 7/9/16, 8/19/16 and 11/15/16 lacked documentation of the Resident experiencing signs or symptoms of psychosis or extreme behaviors. Review of Social Service progress notes dated 3/23/16 - 1/23/17 lacked documentation in regards to the resident experiencing signs/symptoms of psychosis or extreme behaviors. Review of Nurses progress notes between the dates of 6/25/16 - 1/25/17 revealed no documentation in regards to the resident experiencing any signs/symptoms of psychosis or extreme behaviors. A Consultation report form dated 8/16/16 recorded a pharmacist requested the resident's Medical Provider consider decreasing the resident's quetiapine. The form included a recommendation for the Medical Provider to document an assessment of the risks versus benefits of the medication and detailed documentation to support the appropriate use. The Medical Provider responded "...No..." , wrote for no changes in the medication and no clinical rationale to support the continued use. A Consultation report form dated 11/16/16 documented that a pharmacist notified the resident's Medical Provider in regards to a GDR	F 329		

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F 329	Continued From page 45 for quetiapine. The Medical Provider documented the resident as stable on the medication and the form lacked further documentation to support continued use of the quetiapine. A facility Gradual Dose Reduction: Implications for Prescribers form, with a revision date of 1/22/14, included the following: Antipsychotics and antidepressants: A GDR may be clinically contraindicated if a resident's Physician documented a clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability. During interview on 1/25/17 at 8:35 A.M., the facility Director of Nursing identified herself as being responsible to monitor psychotropic medications in the future.	F 329		
F 353 SS=D	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	F 353		

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F 353	Continued From page 46 (Phase 2)] (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 observation, record review, resident interviews, and review of the Resident Council minutes, the facility failed to provide prompt response [within fifteen minutes] to call lights in order to meet the resident's needs (Residents #13, #23). The sample consisted of 17 residents living in the facility and the facility reported a	F 353		

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F 353	Continued From page 47 census of 96 residents. Findings include: 1. Resident #13 had a MDS (Minimum Data Set) assessment with a reference date of 11/18/16. The MDS identified the resident scored a 15 on the BIMS (Brief Interview for Mental Status) test. A score of 15 indicated the resident had no cognitive impairment. The MDS indicated the resident required extensive assistance with activities of daily living (ADL's) including transfers and toilet use. The MDS documented Resident #1 occasionally incontinent of bladder. Resident #13's diagnoses included hemiplegia (paralysis of 1 side of the body) or hemiparesis (weakness of 1 side of the body). The Care Plan dated 7/7/15 identified Resident #13 needed the assistance of 1 person for toileting needs. On 1/25/17 at 10:10 a.m. Resident #13 was interviewed and stated it could take an hour to get the call light answered. The resident stated they also came in, shut the call light off and didn't return, so the call light had to be turned back on with more waiting. Resident #16 stated he/she had experienced incontinence because he/she had to wait too long. 2. Resident #23 had a MDS assessment with a reference date of 10/28/16. The MDS identified the resident scored a BIMS of 12. A score of 12 indicated the resident had a moderate cognitive impairment. Resident #23 required assistance with ADL's including transfers and toilet use. The MDS documented Resident #23 occasionally incontinent of bladder. Resident #1's diagnoses	F 353		

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F 353	Continued From page 48 included diabetes and anxiety disorder. The Care Plan dated 12/20/16 identified Resident #23 with a history of urinary tract infection (UTI) and incontinence of urine. The interventions included Resident #23 needed assistance with toileting. The Care Plan identified Resident #23 at risk for skin breakdown with occasional incontinence. Resident #23 wore underwear. During an observation on 1/24/17 at 1:43 p.m. three call lights were on in the D hall. Staff O Unit Manager went into Resident #23's room turned the call light off and left the room. Staff O then went to two other rooms on the hall, shut off the lights and left the rooms. At 1:58 p.m. Staff P Licensed Practical Nurse (LPN) walked by Resident #23's room, and Resident #23 shouted he/she needed to go to the bathroom real bad. Staff P walked into the nurse's room without addressing the resident. At 1:59 p.m. an activity staff person stopped at Resident #23's door and Resident #23 told the activity person that someone had answered his/her call light, and turned it off and left, and had not returned to assist him/her to the bathroom. The activity person put the call light on. Resident #23 stated she/he hate it when they turn the light off and did not return to help him/her, and repeated having two urinate real bad. At 2:05 p.m. (23 minutes from the time Staff O turned the call light off) staff came to Resident #23's room with an E-Z Stand (sit to stand mechanical lift). The resident stated he/she had been waiting 45 minutes from the first time he/she had activated the call light. During an interview on 1/25/17 at 1:50 p.m. Resident #23 sat in the wheelchair in his or her	F 353		

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F 353	Continued From page 49 room. Resident #23 stated the previous day was not the first time staff had turned his/her light off without helping him/her. Resident #23 said they tell him/her her they have to find an E-Z stand, and they take a long time to return to help him/her. Resident #23 had to put his or her light on again to get help. Resident #23 stated it sometimes takes longer than 45 minutes and he/she had incontinence at times with a prolonged wait for assistance. Resident #23 stated it made him/her feel bad to wet himself/herself. The facility policy and procedure titled, Answering the Call Light, revised June 2015, documented the purpose of the policy was to respond to the resident's requests and needs. The procedures included to do what the resident asked. If they promised to return with an item or information to do so promptly. Review of the December 2016 and January 2017 Resident Council minutes reflected each month the residents voiced concerns about call lights not answered properly and shut off without the resident's needs being addressed.	F 353		
F 363 SS=D	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance;	F 363		

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F 363	Continued From page 50 (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, therapeutic menu review and staff interview, the facility failed to follow a menu as planned to meet nutritional needs for 1 of 17 current residents reviewed (Resident #2). The facility reported a census of 96 residents. Findings included: According to a diagnosis sheet dated 1/24/17, Resident #2's diagnoses included anemia, high blood lipids and diabetes mellitus without complications. A Minimum Data Set (MDS) assessment dated 11/25/16 identified a Brief Interview for Mental Status score of zero, indicating severely impaired memory and cognition. Resident #2 required the assistance of one in order to eat and experienced weight loss in the last 6 months.	F 363		

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F 363	Continued From page 51 A Medication Review Report dated 1/24/17 identified the resident's diet as a regular with pureed texture. Resident #2's care plan with a print date of 1/23/17, include a focus for the the resident being at risk for weight loss and included interventions for staff to assist the resident with eating due to forgetfulness and to encourage the resident to eat. A non decubitus Skin Condition report documented the resident had a reddened and open area to the coccyx which measured 7 by .05 centimeters. A therapeutic menu plan for residents on a pureed diet (for the breakfast meal on 1/24/17), included provision of hot cereal, a fruit choice, pureed egg, pureed sausage and pureed biscuit. Observation on 1/24/17 at 9:45 A.M., revealed Resident #2 sat a dining room table in a wheelchair and Staff C, Certified Nurse Aid/CNA sat next to the resident. During ongoing observation, dietary staff served the resident a bowl of scrambled eggs and a bowl of hot cereal. The resident did not receive sausage, fruit or a biscuit. Observation revealed Staff D fed the resident bites of scrambled eggs and cereal. During interview on 1/24/17 at 9:50 A.M., Staff A, Dietary Cook stated Resident #2 had not received sausage as they had run out. At 9:55 A.M., Staff A confirmed no biscuit had been served to the resident as he never pureed toast or bread. Observation on 1/24/17 at 10:15 A.M., revealed the resident continued to be fed and continued to	F 363		

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F 363	Continued From page 52 take bites of his/her oatmeal and eggs. During interview on 1/24/17 at 10:10 A.M., the facility's Director of Nursing (DON) confirmed the dietary department should not have run out of sausage and the resident needed to be served his/her sausage and bread at the morning meal, most importantly due to his/her weight loss and wound.	F 363		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 53 Based on observation, facility policy review and staff interview, the facility failed to maintain cleanliness in the kitchen to assure sanitary conditions and failed to maintain dish machine wash and final rinse cycle temperatures of 120 degrees Fahrenheit (F) to prevent food borne illness. The facility reported a census of 96 residents. Findings included: 1. Observation during the initial tour of the facility kitchen on 1/23/16 at 8:45 A.M. revealed the following concerns: a. An industrial sized stove/oven combination revealed an excess amount of a black charred substance on the floor of the left side oven. b. A Southbend double oven revealed excess yellow drips down the front of the inside of the oven and had the appearance of grease. The same material covered the metal inside trim. c. A Sharp Carousel microwave revealed excess amounts of yellow spatters on the inside of the microwave as well as dark crumbs on the bottom of the microwave. Review of a facility policy for sanitization in the kitchen with revision date of 12/08 included the need for the food service area to be maintained in a clean and sanitary manner. During interview on 1/24/17 at 9:25 A.M., the Director of Dietary Services confirmed the ovens described above needed to be cleaned. 2. During observation 1/24/17 at 11:20 a.m., Staff F, cook stated he believed the facility had a high temperature sanitizing dishwasher. Staff F placed	F 371		

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F 371	Continued From page 54 a dirty food blender in an Ecolab ES 4000 dishwasher, started the wash cycle and walked away without observing the dishwasher temperatures. Observation revealed the dishwasher a low temperature sanitize dishwasher. A label on the machine directed the minimum wash and rinse cycles required a minimum temperature of 120 degrees F (Fahrenheit). Observation revealed the wash cycle maximum temperature reached 102 degrees F and the rinse cycle reached 120 degrees F. The second cycle revealed a minimum wash temperature of 115 degrees F and minimum rinse cycle of 130 degrees F. The third cycle revealed a minimum wash temperature of 126 degrees F and rinse cycle above 130 degrees F. During an interview at the time. Staff F stated he did not know how to monitor dishwasher temperatures. A Dietary Manager from another facility, present to assist the facility's new Dietary Manager, stated she had a high temperature sanitize dishwasher at her facility and was unaware of the required temperatures for the low temperature sanitize dishwashers. The Dietary Manager checked the chlorine level with an Ecolab strip. The strip read 100 ppm (parts per million). The facility's new Dietary Manager stated she had been a cook before she started her new position and lacked awareness of the required minimum temperatures for a low temperature sanitize dishwasher. Staff G, dietary aide and dishwasher, stated she had written all the test results on the January 2017 Dish Machine Temperature Log. Staff G	F 371		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 55 stated she had not been trained on how to monitor the dishwasher temperatures and she had only documented the sanitizer level on the temperature log sheets. Staff G viewed the January 2017 temperature log and stated she had documented all chemical test results and not dishwasher temperatures. The January 2017 Dish Machine Temperature Log sheet lacked any documentation of temperatures and sanitizer level on 1/1, 1/9, 1/14, 1/15, and 1/16/17. The temperatures documented on the other days ranged from 50 to 100 degrees F. The log revealed evening meal documentation on 1/3, 1/4, 1/7/17, and the other days blank. The Nurse Consultant present during the dishwasher checks and stated she planned to make sure all staff had education on the dish machine temperatures today. The facility Sanitization policy, dated December 2008, directed staff the low temperature chemical sanitize dish machine required a wash temperature of 120 degrees F and a final rinse of 50 ppm chlorine for at least 10 seconds.	F 371		
F 386 SS=E	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and	F 386		

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	165161	A. BUILDING _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 386	Continued From page 56 (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure the availability of current physician recertification orders (including current medication, treatment, and diet orders) for 10 of 17 current residents reviewed (Residents #4, #5, #6 #7, #13, #15 #16, #27, #28 and #29). The facility reported a census of 96 residents. Findings included: 1. Review of Resident #5's clinical record revealed the most current recertification Physician's Orders on the resident's record covered the period of August 2016. The clinical record lacked any additional refortification Physician's Orders as required by the resident's physician at least every 90 days. During an interview on 1/25/17 at 10:35 a.m. Staff B Unit Manager stated they had no current recertification orders for Resident #5. 2. Review of Resident #7's clinical record revealed the most current recertification Physician's Orders on the resident's record covered the period of August 2016. The clinical record lacked complete refortification Physician's Orders as required by the resident's physician at least every 90 days. 3. Review of Resident #13's clinical record	F 386		

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F 386	Continued From page 57 revealed the most current recertification Physician's Orders on the resident's record covered the period of August 2016. The clinical record lacked any additional refortification Physician's Orders as required by the resident's physician at least every 90 days. During an interview on 1/26/17 at 8:40 p.m. the Director of Nursing (DON) provided the most recent orders (August 2016) and stated they had nothing more current. 4. Review of Resident #16's clinical record revealed the most current recertification Physician's Orders on the resident's record covered the period of August 2016. The clinical record lacked any additional recertification Physician's Orders as required by the resident's physician at least every 90 days. 5. Resident #4's clinical record lacked current signed physician's orders. The most recent orders had been signed 8/11/16. 6. Resident #6's clinical record lacked current signed physician's orders. The most recent orders had been signed 8/10/16. 7. Review of Resident #15's record revealed August 2016 Physician's Orders for recertification signed by the physician (without a date). The orders had been noted by facility staff on 8/11/16. The record lacked any more recent recertification orders. 8. Review of Resident #27's record revealed August 2016 Physician's Orders for recertification signed by the physician 8/10/16. The record lacked any more recent recertification orders.	F 386		

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F 386	Continued From page 58 9. Review of Resident #28's record revealed August 2016 Physician's Orders for recertification signed by the physician 8/16/16. The record lacked any more recent recertification orders. 10. Review of Resident #29's record revealed August 2016 Physician's Orders for recertification signed by the physician 8/11/16. The record lacked any more recent recertification orders. During an interview 1/25/17 at 4:30 p.m., the DON stated she was aware several resident's lacked signed physician renewal orders after August 2016.	F 386		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		

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F 441	Continued From page 59 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 60 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to follow infection control measures for 1 of 2 residents reviewed who required oxygen therapy (Resident #15). The facility reported a census of 96 residents. Findings included: Resident #15's Physician's Orders documented an order for oxygen at 4 liters a minute via nasal cannula as needed for shortness of breath to keep oxygen saturation levels above 88%. The order showed an initiation date of 9/23/16. A respiratory services form dated 12/10/15 documented diagnoses that included congestive heart failure and respiratory insufficiency. During observation on 1/25/17 at 9:47 a.m. Staff J, Certified Nursing Assistant (CNA) pushed the resident in a wheelchair from the Spa (shower) room. The resident's oxygen tubing and nasal cannula dragged on the floor behind the wheelchair. In the hallway, Staff J reeled in the tubing, handed it to the resident and directed Resident #15 to put it in his/her nose. The resident complied. During interview on 1/25/17 at 2:17 p.m. the Director of Nursing stated the oxygen tubing should have been replaced after contact with the floor. The DON stated the tubing should be changed weekly and documented in the	F 441		

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F 441	Continued From page 61 Medication Administration Record (MAR) or Treatment Administration Record (TAR). She stated staff also date the oxygen tubing when replacing it. During observation on 1/25/17 at 2:24 p.m. the resident sat in his/her room watching television. The resident had oxygen administered from a portable concentrator on the back of the wheelchair via nasal cannula. A piece of tape on the tubing had 12/4 written on it. The DON confirmed the date as December 4th. The resident also had a larger concentrator used in bed which sat between the bed and the wall. The concentrator had a heavy accumulation of dust and the tubing on that concentrator also showed a date of 12/4.	F 441		
F 496 SS=D	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	F 496		

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F 496	Continued From page 62 (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to verify nurse aide registry eligibility prior to employment for 1 of 4 staff reviewed (Staff C). The facility reported a census of 96 residents. Findings include: 1. A facility list of new employee hires, printed 1/23/17, identified Staff C, CNA (Certified Nursing Assistant), had a hire date of 9/24/16. Staff C's personnel file had a Single Contact License and Background Check sheet, dated 9/15/16, that lacked a check of Staff C's nurse aide eligibility. During an interview 1/25/17 at 12:15 p.m., the Nurse Consultant stated the facility had failed to verify Staff C's nurse aide eligibility prior to hire and had completed the eligibility on 1/24/17.	F 496		

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F 520	Continued From page 63	F 520		
F 520 SS=C	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		

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F 520	Continued From page 64 (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility record and policy review and staff interview, the facility failed to assure that quarterly Quality Assessment and Assurance meetings had the required members in attendance at least quarterly. The facility reported a current census of 96 residents. Findings included: Review of the facility's Quarterly Quality Assurance and Performance Improvement (QAPI) meeting sign in sheets revealed the Medical Director or another physician had not attended a quarterly meeting since 8/25/16. The facility had a sign in sheet for a meeting held on 11/22/16 meeting and a physician had not signed the sheet. During an interview 1/25/17 at 3:00 p.m., neither the Administrator or Interim DON (Director of Nursing) was aware of why a physician had not attended the meeting. The facility's 2014 QAPI Purpose, Guiding Principles and Scope for QAPI information, page 6, documented the facility would assure the Medical Director had active involvement on the committee and attended meetings at least quarterly.	F 520		

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F156 Notice of Rights, Rules, Services, Charges

Immediate corrective action:

R26 continues to remain at the facility and is no longer under Medicare A services.

Action as it applies to others:

All residents residing in the facility under Medicare Services have the potential to be affected.

Education on completion and issuance of a Notice of Medicare Provider Non-Coverage form and Skilled Nursing Facility Advanced Beneficiary Form prior to a resident's discharge from Medicare Part A Services has been completed with the Social Services Department.

Date of completion: 02/26/17

Recurrence will be prevented by:

Daily Medicare huddle meeting will be completed 5 days a week with review of approaching Medicare A discharges.

The correction will be monitored by: Administrator/designee will complete audits three days a week for four weeks. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/designee

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F226 Develop/Implement Ab use/Neglect, ETC Policies

Immediate corrective action:

Staff D's SING has been completed, employment eligibility verified and is in the employee's file.

Staff E has completed the correct Mandatory Reporter training and it is in the employee's file.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

All employee personnel files have been audited to ensure SINGs completed and correct Mandatory reporter training has occurred and in employees' files.

Date of completion: 02/10/17

Recurrence will be prevented by:

A new Human Resources Director has been hired. A new hire spreadsheet has been implemented to ensure all mandatory requirements have been met.

The correction will be monitored by: Administrator/designee will complete audits three times weekly for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/designee

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F241 Dignity and Respect of Individuality

Immediate corrective action:

R15 continues to reside at the facility and has suffered no ill effect from the deficient practice. R15 has been screened by therapy for safe transfers. R15 will be transferred using the mechanical sit to stand for all transfers.

Action as it applies to others:

All residents residing in the facility that require assist with transfers have the potential to be affected.

Education has been completed with nursing department staff on resident choices, following the care plan for transfers.

Date of completion: 02/26/17

Recurrence will be prevented by:

An audit of residents requiring mechanical lift transfers has been completed to ensure current transfer status is accurate.

The correction will be monitored by: Administrator/designee will complete audit tools three times weekly to ensure compliance with mechanical transfers. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F252 Safe/Clean/Comfortable/Homelike Environment

Immediate corrective action:

The facility is receiving bids for replacing the hand rails, doors, closet doors. The chest has been replaced in room A7 and room A4. Room C5 has the hole in the wall fixed. The rough edges of wood have been repaired.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to staff on identifying maintenance needs and completing work orders.

Date of completion: 2/26/17

Recurrence will be prevented by:

Managers will round daily five days a week and will identify areas where maintenance is needed.

The correction will be monitored by: Administrator/designee will monitor work orders three times a week for four weeks turned in by staff or others to insure completion.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F279 Develop Comprehensive Care Plans

Immediate corrective action:

An audit has been completed on all residents receiving antipsychotic medications and anticoagulants to ensure all have a current care plans addressing the medication use and interventions are in place.

R3's care plan has been updated to include antipsychotic medication usage and interventions.

R10's care plan has been updated to include psychotropic medication use and interventions as well as the cardiac pacemaker, Coumadin use, diagnosis and interventions.

R8's care plan has been updated to include anticoagulant and antipsychotic use and side effects/interventions of both.

R12 's no longer receives psychotropic medications.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been completed with nurse managers on updating care plans with changes in cares, medications, behaviors, etc.

Date of completion: 02/26/17

Recurrence will be prevented by:

Nurse managers will review progress notes daily five days a week for changes in condition, psychotropic medication changes, anticoagulant changes.

The correction will be monitored by: Administrator/designee will complete audit tools three times weekly for four weeks to ensure changes in condition, psychotropic and anticoagulant medication changes have been added to the care plan. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F281 Services Provided Meet Professional Standards

Immediate corrective action:

An audit has been completed to identify all residents on a weight schedule to ensure they are entered into the electronic medical record.

R10 and R15 remain at the facility.

Action as it applies to others:

All residents residing in the facility that are on a weight schedule have the potential to be affected.

Education has been provided to the nursing department on weight policy and procedure and documentation in the electronic record of the weight.

Date of completion: 02/26/17

Recurrence will be prevented by:

Scheduled weights will be reviewed in daily by nurse managers five days a week.

Weight meetings will be held weekly for reviews of weight loss and recommendations.

The correction will be monitored by: Administrator/designee will complete audit tools three days a week for four weeks to ensure compliance with obtaining the scheduled weights and documentation on weights. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F282 Services by Qualified Persons/Per Care Plan

Immediate corrective action:

An audit of residents with care plan interventions including ambulation has been completed.

R10 continues to reside at the facility.

An audit of residents requiring off-loading boots/heel protectors has been completed.

R7 continues to reside at the facility.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been completed on following the care plan for interventions using the Kardex.

Date of completion: 02/26/17

Recurrence will be prevented by:

New orders will be reviewed daily five days a week by the nurse managers to ensure any new interventions are included in the care plan and that the interventions are on the Kardex and communicated to staff.

The correction will be monitored by: Administrator/designee will complete audit tools three times weekly for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F285 PASRR Requirements for MI & MR

Immediate corrective action:

Resident's #9, #21, and #22 continue to reside at the facility.

An audit has been completed to ensure all residents with PASRR recommendations have those recommendations completed and are on the care plan.

Action as it applies to others:

All residents in the facility with PASRR recommendations have the potential to be affected.

Education has been provided to Social Services staff and Nursing Department managers on follow through with PASRR recommendations and care plans.

Date of completion: 02/26/17

Recurrence will be prevented by:

Nurse managers will review new orders, recommendations five days a week to ensure follow through.

The correction will be monitored by: Administrator/designee will complete audit tools to ensure compliance with recommendation follow through and care plan revisions. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F309 Provide Care/Services for Highest Well Being

Immediate corrective action:

R4 continues to reside at the facility and has suffered no ill effects from the deficient practice. Bowel protocol orders have been obtained.

R15 continues to reside at the facility. R15 received a swallow evaluation with no abnormalities noted. R15 is currently working with Speech Therapy for cognition.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to the nursing department on bowel protocol, bowel documentation, follow up with dietician recommendations, physician's orders and documentation of change of condition.

Date of completion: 02/26/17

Recurrence will be prevented by:

BM alert documentation will be reviewed five days a week by nurse managers.

Progress notes will be reviewed five days a week by unit managers for changes in condition and follow through on dietician recommendations and physician's orders.

Weekly weight meetings to review dietician recommendations, weight changes.

The correction will be monitored by: Administrator/designee will complete audit tools three times weekly for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F317 No Reduction in ROM Unless Unavoidable

Immediate corrective action:

R4 and R6 continue to reside at the facility and are currently in a restorative program.

An audit has been completed of therapy recommendations for the past 60 days to ensure all have been followed through.

CASPER report was reviewed for residents with a decline in ADLs and restorative programs initiated.

Action as it applies to others:

All residents with a potential for decline in ROM have the potential to be affected.

A therapy/nursing communication tool has been implemented to ensure communication between therapy and nursing for recommendations for restorative programs.

Education has been completed with therapy and nurse managers on communication and follow through with therapy recommendations for restorative programs.

Date of completion: 02/26/17

Recurrence will be prevented by:

Therapy recommendations will be reviewed five days a week to ensure completion of follow through.

The correction will be monitored by: Administrator/designee will complete audit tools three days a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F323 Free of Accident Hazards/Supervision/Devices

Immediate corrective action:

R5 continues to reside at the facility. R5's care plan has been reviewed and revised to include resident's history of physical contact with others and interventions to keep others safe when R5 becomes upset.

R8 continues to reside at the facility. The motorized recliner has been removed from the resident's room and replaced with a non-motorized recliner per resident and family request. R8's care plan has been reviewed/revised to ensure current interventions are in place.

Action as it applies to others:

All residents residing at the facility have the potential to be affected.

Education has been provided to the nursing department on including history of physical aggression and interventions for safety on the resident's care plan.

Education has also been provided to the nursing department on ensuring fall interventions remain intact when a resident goes to the hospital and returns or has a room move and that the care plan is updated to reflect current interventions.

Date of completion: 02/26/17

Recurrence will be prevented by:

Incident reports will be reviewed five days a week by the nurse management team. Care plans for those that have had a behavior or fall will be reviewed and revised for accuracy.

The correction will be monitored by: Administrator/designee will complete audits three times weekly to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F329 Drug Regimen is Free from Unnecessary Drugs

Immediate corrective action:

R2 and R3 continue to reside at the facility. Both residents have had a GDR sent to the physician for approval.

An audit has been completed on all GDR's dated the past 60 days to ensure all were addressed by the physician. The pharmacy consultant has been contacted to review all antipsychotics for when next GDR is due.

Action as it applies to others:

All resident's receiving antipsychotic medications have the potential to be affected.

Education has been provided to ensure tracking and follow through with GDRs.

Education has also been provided on documentation of signs and symptoms, behaviors in the progress notes.

Date of completion: 02/26/17

Recurrence will be prevented by:

A tracking tool has been implemented to track antipsychotic medications to ensure all have current dx, GDRs are current, consents obtained, target behaviors addressed.

New antipsychotic medication orders or changes in dosages will be reviewed five days a week by nurse managers with tracking tool utilized for follow through accuracy.

The correction will be monitored by: Administrator/designee will complete audit tools three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date:02/20/17

F353 Sufficient 24-HR Nursing Staff Per Care Plans

Immediate corrective action:

R13 and R23 continue to reside at the facility.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to all staff on answering call lights, finding assistance if unable to fulfill needs, leaving call light on until needs are met.

Date of completion: 02/10/17

Recurrence will be prevented by:

Managers have been assigned to all resident rooms to check with residents five days a week to ensure call light response time is improved.

The correction will be monitored by: Administrator/designee will complete audit tools three days a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F363 Menus Meet Res Needs/Prep In Advance/Followed

Immediate corrective action:

R2 continues to reside at the facility and has suffered no further weight loss.

Action as it applies to others:

All residents residing at the facility at risk for weight loss have the potential to be affected.

Education has been completed with the dietary department on menu planning/ordering and what steps to take if a menu item is unavailable.

Date of completion: 02/26/17

Recurrence will be prevented by:

Meal assistance from managers is now in place for three meals a day 5-7 days a week to ensure all are given full meals as on menu.

The correction will be monitored by: Administrator/designee will complete audit tools three days a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F371 Food Procure, Store/Prepare/Serve-Sanitary

Immediate corrective action:

The kitchen has been deep cleaned.

A cleaning schedule is available and in use by the dietary department.

The dishwasher was checked and the temperature remains in the appropriate temperature ranges.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to all dietary staff on temperatures and sanitizer level and documentation of temperatures and levels.

Date of completion: 02/26/17

Recurrence will be prevented by:

Dietary staff will document temperatures and sanitizer levels on facility approved forms when dishwasher is in use.

The correction will be monitored by: Administrator/designee will complete audit tools three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F386 Physician Visits-Review Care/Notes/Orders

Immediate corrective action:

Residents R4, R5, R6, R7, R13, R15, R16, R27, R28, and R29 continue to reside at the facility.

All resident's physician's orders have been sent to the physician's for recertification.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

The facility has hired a new medical records manager.

Education has been provided to the new medical records manager along with the nurse managers to ensure recertification's are mailed to physician's and are returned signed and on the resident's chart.

Date of completion: 02/26/17

Recurrence will be prevented by:

The facility has implemented a tracking tool for medical records to track when orders are sent to physician for recertification and when they are returned signed.

The correction will be monitored by: Administrator/designee will complete audit tools three times weekly for four weeks to ensure all are returned from physician, signed and on the resident's chart.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F441 Infection Control, Prevent Spread, Linens

Immediate corrective action:

R15 continues to reside at the facility and remains on oxygen. R15s oxygen tubing has been changed weekly and prn.

R15s oxygen concentrator was cleaned.

Action as it applies to others:

All residents requiring oxygen in the facility have the potential to be affected.

Education has been provided to nursing department staff on n changing oxygen tubing weekly, bagging when not in use, cleaning the concentrators and replacing tubing when contaminated.

Date of completion: 02/26/17

Recurrence will be prevented by:

Oxygen tubing changes will be documented as completed on the electronic E-Mar/E-TAR.

The correction will be monitored by: Administrator/designee will complete audit tools three times weekly for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F496 Nurse Aide Registry Verification, Retraining

Immediate corrective action:

Staff C's nurse aide eligibility has been confirmed and is in his/her employee file.

An audit of nurse aide employee files has been conducted to ensure all requirements of employment have been met.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

The facility has hired a new Human Resource Manager and education has been provided on required steps/checks for nurses and nurse aides prior to start of employment.

Date of completion: 02/26/17

Recurrence will be prevented by:

The facility has implemented a spreadsheet with all of the requirements pre-employment which will be utilized for all new hires.

The correction will be monitored by: Administrator/designee will complete audit tools three times a week for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

Touchstone Healthcare Community Plan of Correction

Date: 02/20/17

F520 QAA Committee-Members/Meet Quarterly/Plans

Immediate corrective action:

The facility has a QAA Committee meeting scheduled for February 23, 2017 as this was the earliest the Medical Director could attend.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to the QAA Committee on scheduling and attendance of QAA meetings.

Date of completion: 02/26/17

Recurrence will be prevented by:

Future QAA meetings will be scheduled at the end of the current QAA meeting and a reminder will be sent out prior to the meeting.

The correction will be monitored by: Administrator/designee will complete the QAA Meeting minutes and place in QAA binder.