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	165569	A. BUILDING _____ B. WING _____	01/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT CARE CENTER INC	**607 6TH STREET PO BOX 398 WEST POINT, IA 52656**

(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_____ The following deficiencies result from the facility's annual health survey. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

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

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F 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident, family and staff interview, the facility failed to update a care plan after the resident developed a contracture to the left hand for one of 26 residents reviewed (Resident #27). The facility reported a census of 28 residents. Findings include: Resident #27's Minimum Data Set (MDS) assessment completed 12/19/17 documented she had diagnoses that included diabetes mellitus, cerebrovascular accident (stroke) and subsequent MI of inferior wall (heart attack). It also identified the resident had a BIMS score of 12 out of 15, indicating moderately impaired memory and cognition. The resident required the assistance of two staff with bed mobility, transfers and toilet use and the assistance of one with locomotion, dressing and personal hygiene. The resident had range of motion impairment in one arm and one leg. Review Resident #27's care plan with the goal target date of 3/18/18 identified the resident with the problem of self-care deficit as evidenced by diagnoses of stroke and left sided weakness. The care plan instructed Resident #27 will actively participate in restorative (without documentation of the frequency and type of restorative activities) and to encourage the resident to keep his/her left armrest provided on the wheelchair. The care plan contained no information about contracture of the resident's left fingers. During the interview on 1/10/18 at 1:03 p.m., the	F 657		

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F 657	Continued From page 2 resident and her spouse reported she got therapy on the bicycle at the facility 3 times a week, but no no exercises here to get strong enough to stand. An observation at that time revealed contractures to all the fingers on the left hand. A review of the hospital discharge summary dated 4/13/17 revealed no contractures to the left hand. A review of the admission nurse's note dated 4/13/17 at 1:14 p.m. revealed the resident had no contractures or skeletal deformities at this time. A review of the nurse's notes from 9/5/17 through 1/18/18 revealed only one entry which addressed the resident's left hand on 1/11/16 at 10:11 a.m. resting hand splint to left hand/wrist for proper hand position to prevent flexion contracture. In an interview on 1/17/18 at 2:00 a.m., Staff B, CNA (certified nursing assistant) reported she the resident did not usually use the left hand as she could not straighten out those fingers which has been that way as long as she could remember. During an interview on 1/17/18 at 8:51 a.m., the Director of Nursing, (DON) reported the care plan should be updated by the MDS coordinator, but currently the facility is in the process of training a new person for that position. The DON reported she would expect a new contracture to be updated on the care plan.	F 657		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		

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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; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident, family and staff interviews, the facility failed to prevent contractures to Resident #27's left hand and fingers. The sample consisted of 12 residents and the facility reported a census of 28 residents.

Findings include:

Resident #27 had a MDS (Minimum Data Set) assessment with a reference date of 2/19/17. The MDS identified the resident had diagnoses: diabetes mellitus, cerebrovascular accident (stroke) and subsequent MI of inferior wall (heart attack). The MDS identified the resident to be cognitively intact with a BIMS (brief interview for mental status) score of 12 out of 15. A score of 12 identified the resident to be moderately cognitively impaired. The MDS identified the resident as totally dependent on staff for most activities of daily living and had impairment to one side of both the arm and leg.

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The Care Plan with a goal target date of 3/18/18 identified a problem of self-care deficit as evidenced by diagnosis of a stroke and left sided weakness. The Care Plan interventions included and directed the staff to:

The resident will actively participate in restorative (no documentation of frequency and type),

Encourage the resident to keep her provided left armrest on the wheelchair,
No documentation to address the contracture of fingers to her left arm

On 01/10/18 at 01:03 p.m. the resident and spouse reported the following:
The resident stated she received bicycle therapy at the facility 3 times a week, no exercises here to get me strong enough to stand, but they do this for me at the hospital where I go 2 times a week. The resident stated she could not open up her left hand all the way. An observation at that time identified contractures to all the fingers on the left hand.

The resident's spouse reported the following:
They [spouse and resident] were told that Medicare ran out and we were private pay. Therapy just stopped. All they [facility] had her do was use the bicycle. We want her to walk, stand and to be able to go home. The spouse stated the doctor informed there was no reason she should not be able to stand and walk with a walker.

On 1/17/18 6:35 a.m. Staff F, restorative aide/CMA was observed performing range of motion exercises to the resident's left arm and to

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the left hand. Staff F had the resident straighten out her fingers. The resident could not achieve extension to the left hand fingers due to pain and then the resident requested pain medication.

On 1/17/18 at 06:46 a.m. the resident was observed to do 10 repetitions of leg lifts to both legs, bending at the knee. The resident then marched in place while sitting in the wheelchair and unable to lift the left foot as much as the right foot. Staff F then locked the resident's wheelchair, held the resident's hands and asked her to lean forward then back for 10 repetitions. On 1/17/18 at 06:48 a.m. Staff F unlocked the resident's wheelchair and pushed the resident in front of the omnicycle which the resident pedaled for a full 15 minutes before returning to her room.

A review of the hospital discharge summary dated 4/13/17 identified the resident had no contractures to the left hand.

A review of the admission Nurse's Note dated 4/13/17 at 1:14 p.m. indicated the resident had no contractures or skeletal deformities at this time.

A review of the Nurse's Notes from 9/5/17 through 1/18/18 identified only one entry that addressed the resident's left hand on 1/11/16 at 10:11 a.m. - resting hand splint to left hand/wrist for proper hand position to prevent flexion contracture. The documentation identified no documentation of a contracture to the fingers on the resident's left hand.

The Director of Nursing (DON) entries in the resident's record revealed the following:
On 9/21/17 at 1:17 p.m., 10/18/17 at 1:00 p.m., 11/8/17 at 11:26 a.m., and 12/21/17 at 11:29 a.m.

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each entry had the following documentation under restorative program note: Met with restorative aide today and the resident participated in the current restorative program without complaints, no concerns at this time with limitations. Will continue current plan of care and proceed with referrals and make modifications as needed.
On 1/12/18 at 3:00 p.m. met with restorative aide today and resident is participating in the current restorative program without complaints, no concerns at this time with limitations. The resident also goes to outpatient therapy at the local hospital 1-2 times per week. Will continue current plan of care and proceed with referrals and make modifications as needed.

A review of the occupational therapy evaluation and plan of treatment for the certification period 8/22/17 to 11/15/17 had documentation the left arm with impairment at the shoulder and elbow and demonstrated the beginning of contracture development, especially in the left fingers with loss of extension.

A review of the physical therapy discharge summary with dates of service from 4/13/17 to 7/27/17 revealed the interventions provided: therapeutic activities: transfer training to increase functional task performance, training in rolling, scooting, bridging to facilitate bed mobility and bed mobility activities to increase functional skills. The reason for discharge: highest practical level achieved.

A review of the occupational therapy discharge summary with dates of service from 8/22/17 to 9/11/17 revealed the interventions provided: therapeutic activities: gross motor coordination, crossing midline to facilitate independence in

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functional skill performance, weight shifting to improve safety with unsupported sit/stand, static balance activities during sitting, dynamic balance activities during sitting, placement of objects out of reach to increase dynamic skill performance, range of motion techniques to increase functional task performance, analysis/training in cueing hierarchy to increase strength. Discharge recommendations: functional maintenance program/restorative nursing program and 24 hour care.

A review of the hospital outpatient rehabilitation services center dated 12/21/17 had documentation of the following:
Reason for referral: resident reports she had a total knee replacement in January 2017, had several strokes and a heart attack following that surgery, has not had any therapy for the past 4 months at the nursing home and has goals to be able to start transferring again, possibly ambulate and dress herself.
Objective: left hand has some flexion contractures in all digits except thumb.
Short term goals:
Will be able to demonstrate fair to good tolerance working on static and dynamic sitting balance in preparation for increasing independence with activities of daily living including that of dressing supine or sitting
Will demonstrate good tolerance for custom resting hand orthotic to assist with decreasing flexion contractures on left hand/digits to allow for eventual increase use of the left hand

A review of the patient visit information dated 12/8/17 by the neurologist revealed the resident had spastic hemiplegia (paralysis on one side) affecting the left non-dominant side and had

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orders for physical therapy and occupational therapy for lower strengthening three times a week for 4 weeks and upper extremity ROM (Range of Motion) and strengthening 2-3 times a week for 4 weeks

A review of the restorative care documentation on the survey report v2 revealed the following: November 2017 had no documentation of restorative care given from 11/24/17 through 11/30/17, December 2017 had documentation that restorative care provided only 2 days during the week of 12/10/17 through 12/17/17 and during 12/18/17 through 12/24/17

On 1/16/18 at 2:00 p.m., Staff F, restorative aide, was interviewed and stated the resident was getting ready to leave for the day to receive therapy at the hospital as per the family's request.

On 1/17/18 at 2:00 p.m., Staff B, CNA reported she could not recall when the resident began restorative care and the resident did not usually use the left hand as the resident could not straighten out those fingers.

On 1/17/18 at 02:23 a.m., Staff C, CNA reported when she first worked at the facility, she thought the resident had a contracture to the left hand which he/she should wear a brace to the left hand all the time. The resident is to have the left hand strapped to the armrest of the wheelchair when he/she goes to therapy. Staff C reported she has not seen the resident able to straighten out the fingers to her left hand as it is really difficult for her.

On 1/17/18 at 2:30 p.m., Staff D, RN was interviewed and stated since she began working at the facility (date unknown), the resident's left

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hand had always been contracted and the resident unable to fully straighten out the fingers to the left hand. Staff D stated 2 to 3 weeks ago, therapy placed a splint to her left hand. Staff D could not recall what was done for restorative care. The resident went to the hospital for therapy per the family's choice perhaps because they did not think our program was aggressive enough.

During an interview on 1/17/18 at 7:35 a.m., Staff F, restorative aide/CMA reported the resident had the contracture to the left hand upon admission to the facility which restorative care included trying to straighten out the fingers to the left hand. She reported she worked with the resident 5 days a week as long as the resident is in the facility.

On 1/17/18 at 11:27 a.m. the physical therapy program coordinator/PTA, reported a physical therapist had oversight over the program and came to the facility twice a week. When the resident was admitted to the facility in April 2017, physical therapy worked with her from April through July without contractures during that time frame. After discharge from the program in July, we began to notice tightness in her left hand. We picked her up again for therapy in August under Part B. The resident was discharged from Part B from occupational therapy in September 2017 as there was no contracture, just tightness. The goal was to discharge from therapy and work with restorative program - complete passive ROM (to perform joint range of motion for a person) LUE (left upper extremities), hand focus on straightening fingers completely. Restorative care was provided from September 2017 to present. She then reviewed the outpatient note on 12/21/17 and addressed the resident's

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F 688	Continued From page 10 contracture and verified this was the initial evaluation. During an interview on 1/18/18 at 8:24 a.m., the physical therapist with oversight over the facility program reported physical therapy primarily worked on the resident's legs and occupational therapy worked on the resident's arms. When asked what her expectation would be to prevent contractures from occurring, she reported she would expect a restorative program in place where the resident should be seen at least 5 times a week. During an interview on 1/17/18 08:51 a.m., the Director of Nursing, (DON) reported the Care Plan should be updated by the MDS coordinator, but currently the facility is in the process of training a new person for that position. The DON reported she would expect a new contracture to be updated on the Care Plan.	F 688		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(a)(1) The facility must provide services	F 725		

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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.

§483.35(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.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to answer call lights in a timely manner to meet the needs of 2 of 5 interviewable residents in the group interview and for 2 of 12 residents reviewed (Residents #16 and #27). The facility reported a census of 28 residents.

Findings included:

1. On 1/10/18 at 1:30 p.m. a group of residents were interviewed. All 5 residents were interviewable and 2 of the 5 residents stated they had to wait more than 30 minutes for staff to respond to their activation of the call light. The 2 residents stated this happened on all shifts and on a regular basis. Both residents stated they had either a cell phone or watch/clock in their rooms to time the call light response.

2. Resident #16 had a Minimum Data Set (MDS) assessment with a reference date of 11/14/17. The MDS identified the resident had diagnoses including peripheral vascular disease, unilateral primary osteoarthritis unspecified knee and pain

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in unspecified knee. The MDS indicated a BIMS (Brief Interview for Mental Status) score of 14 out of 15. A score of 14 identified the resident without cognitive impairments. The MDS indicated the resident required extensive staff assistance for most activities of daily living and experienced an occasional bladder and bowel incontinent episodes.

The Care Plan with the goal target date of 2/19/18 identified a problem with being able to do own activities of daily living due to weakness, secondary to knee pain and osteoarthritis. The Care Plan directed for 2 staff members to assist the resident with toileting upon rising, before meals and at bedtime and to assist with brief changes, cleansing and check for incontinence.

A review of the January 2018 medication administration record (MAR) and physician orders dated 12/1/17 had documentation of the following orders:
Docusate sodium (used to treat constipation) capsule 100 milligram (mg) give 2 capsules one time a day,
Furosemide (diuretic which promotes the increased production of urine) 40 mg one tablet two times a day, administer with 80 mg tablet to equal 120 mg,
Furosemide 80 mg one tablet two times a day administer with 80 mg tablet to equal 120 mg.

On 01/10/18 at 9:47 a.m. the resident reported she had to wait as long as 30 minutes for the call light to be answered. Staff #16 stated usually on the night shift, once a week and has experienced problems losing control with bowel and bladder incontinence while waiting to go to the bathroom. The resident reported "This makes me feel

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horrible." During the interview, an observation identified a clock hung on a wall across from the foot of the bed. The clock could be easily visible from the bed and recliner.

3. Resident #27 had a MDS assessment with a reference date of 12/19/17. The MDS identified the resident had diagnoses that included diabetes mellitus, cerebrovascular accident (stroke) and subsequent MI of inferior wall (heart attack). The MDS indicated the BIMS score of 12 out of 15. A score of 12 represented a moderate cognitive impairment. The MDS indicated the resident as totally dependent on staff for most activities of daily living, frequently incontinent of bladder and always continent of bowel.

The Care Plan with the goal target date of 3/18/18 identified the resident with the problem of a self-care deficit as evidenced by diagnosis of stroke, left sided weakness and directed staff to: toilet the resident in the morning and at bedtime, before or after meals and as needed and provide pericare as needed.

During an interview on 01/10/18 at 12:33 p.m., the resident reported "I have had to wait as long as 25 minutes to get my call light answered, happens on all different shifts. No episodes of incontinence waiting for help to the bathroom. This happens at least once a week." During the interview, an observation revealed a clock hung on a wall across the foot of the bed, easily visible from the bed and recliner.

During an interview on 1/16/18 at 09:30 a.m. Staff G, CNA, reported that day there are a total of 3 CNAs working both hallways and two nurses.

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In an interview on 1/17/18 at 02:00 a.m., Staff B, CNA reported the staffing on night shift usually included 2 CNAs and one nurse and felt that is enough help to do her job and that no residents have complained to her about not getting call lights answered.

During an interview on 1/17/18 at 02:23 a.m., Staff C, CNA reported the staffing on night shift included one nurse and 2 aides, felt that is enough help to do her job and that no residents have complained to me about not getting call lights answered in a timely manner, especially at night because it's pretty slow at night.

In an interview on 1/17/18 02:30 a.m., Staff D, RN reported staffing on night shift included one nurse and 2 aides which works out really well. She also reported only one resident complained of not getting call lights answered timely, but has never said how long he/she had waited.

On 1/17/18 8:51 a.m., the Director of Nursing, (DON) was interviewed and stated she would expect the staff to answer call lights right away. The DON stated she was unsure if the facility had a policy that addressed the length of time lights are allowed to be on before staff answers.

A review of the facility policy and procedures titled, Answering The Call Light (revised 10/17) did not direct the staff to respond to a call light within 15 minutes. The policy directed staff to do the following steps:
a. Turn off the signal light,
b. Identify yourself and the resident by his/her name,
c. Listen to the resident's request,
d. Do what the resident asks of you, if permitted,

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F 725	Continued From page 15 If you are uncertain as to whether or not request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance, e. If you have promised the resident you will return with an item or information, do so promptly, f. If assistance is needed when you enter the room, summon help by using the call signal.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		

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written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on record review and and staff interview, the facility failed to post complete nurse staffing on a daily basis. The facility reported a census of 28 residents.

Findings include:

Review of the facility's staff posting on the following dates and times revealed:

a. On 1/11/18 a 7:24 a.m., the facility posted staffing on a clipboard at nurse's station dated 1/11/18 but it contained staff only for the night shift written as 8 hours RN (Registered Nurse) and 16 hours of CNA (certified nursing assistant) without hours written for day or afternoon shifts.
b. On 1/11/18 at 8:45 a.m. the staff posting remained unchanged.
c. On 1/16/18 at 2:23 p.m. the facility posted staffing dated 1/16/18 with census of 28 and no documentation of hours for evening shift.
d. On 1/17/18 at 1:52 a.m., the facility posted staffing at nurse's station dated 1/17/18 with documentation only of census of 28 and staffing for night shift (one RN and 2 CNAs).

During an interview on 1/17/18 at 8:51 a.m., the Director of Nursing reported each shift is

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F 732	Continued From page 17 responsible for completing the posting and night shift is the shift that posts it.	F 732		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to ensure medication error rates of less than or equal to 5% with a medication error rate of 7.14% (2 errors out of a total of 28 medications administered). The facility reported a census of 28 residents. Findings include: 1. Resident #18's Minimum Data Set (MDS) assessment dated 11/22/17 documented she had diagnoses that included Alzheimer's disease, dementia and muscle weakness. The assessment documented the resident had a brief interview for mental status (BIMS) score of 4 out of 15, indicating severely impaired cognition. Resident #18 required the assistance of one to two staff to complete activities of daily living. Review of Resident #18's 1/18 medication administration record (MAR) and physician orders on the medication review report dated 12/1/17 revealed orders to instill Betimol solution 0.5% (Timolol Hemilhydrate) one drop in both eyes one time a day for glaucoma.	F 759		

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During an observation of a medication pass on 1/11/18 at 07:00 a.m., Staff E, LPN (Licensed Practical Nurse) administered one drop of Timolol 0.5% to the left eye, covered the bottle, removed her gloves, washed her hands and gave the resident a drink of water and spoon fed the resident all oral medications. She did not administer Timolol to the right eye as ordered. After administration, Staff E, LPN verified the resident had orders to receive Timolol one drop to each eye and she swore she gave one drop in each eye.

2. Resident #24's MDS assessment dated 12/28/17 documented she had diagnoses that included renal (kidney) disease, diabetes mellitus and cataracts, glaucoma or macular degeneration. The assessment documented a BIMS score of 11, indicating moderate cognitive impairment. She required staff assistance with most activities of daily living except eating.

Review of the resident's 1/18 MAR and physician orders on the medication review report dated 12/1/17 revealed direction to administer Brimonidine Tartrate-Timolol 0.2-0.5% 2 drops in the right eye once a day and Pred Forte suspension 1% (Prednisolone acetate) one drop in the right eye once a day

During an observation of a medication pass on 1/11/18 at 6:14 a.m., Staff E administered Brimonidine Tartrate-Timolol 0.2-0.5% one drop to the resident's right eye, changed her gloves and then administered Prednisolone two drops to the right eye. After returning to the medication cart, she checked the MAR and stated that she did that wrong. Staff E stated she gave the resident 2 drops of Prednisolone when she

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F 759	Continued From page 19 should have had 2 drops of the Timolol and got it backwards. During an interview on 1/17/18 at 8:51 a.m., the Director of Nursing, (DON) reported when administering eye drops, her expectation of nurses is to understand what they are doing. The facility had inserviced staff on different types of meds and she would expect the nurse to follow the 5 rights: check the order, right person, right dose, right eyes, etc.	F 759		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interviews, the facility failed to offer residents	F 809		

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a bedtime snack for 5 of 5 interviewable residents in the group interview and 1 of 26 sampled residents (Resident #27). The facility reported a census of 28 residents.

Findings include:

1. During the group interview on 1/10/18 at 1:30 p.m., 5 of 5 interviewable residents present stated staff did not offer them a bedtime snack.

2. Resident #27's Minimum Data Set (MDS) assessment completed 12/19/17 documented she had diagnoses that included diabetes mellitus, cerebrovascular accident (stroke) and subsequent MI of inferior wall (heart attack). It also identified the resident had a BIMS score of 12 out of 15, indicating moderately impaired memory and cognition. The resident required the assistance of two staff with bed mobility, transfers and toilet use and the assistance of one with locomotion, dressing and personal hygiene. The resident ate independently.

The care plan with the goal target date of 3/18/18 documented a focus of the resident's risk for side effects from medication usage, hypoglycemia. The care plan directed staff to understand the signs and symptoms of hypoglycemia to report to nursing. The signs and symptoms include but are not limited to: confusion, vision changes, diaphoresis.

During an interview on 1/10/18 at 12:39 p.m., Resident #27 reported staff come by with the snack cart but not every night. She also reported she had alot of episodes with low blood sugars and that morning it measured 71. The resident also reported being on insulin twice a day and

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F 809	Continued From page 21 before meals. A review of the Medication Administration Records revealed no documentation of bedtime snacks being given to the resident. A review of the documentation in the electronic medical record under HS (hour of sleep) snacks revealed the following: a. 10/27/17 - No documentation that staff offered a snack. b. 11/1/17 - Staff left the area blank. c. 12/17/17 - Staff did not offer a snack In an interview on 1/17/18 at 2:30 a.m., Staff D, RN (Registered Nuse) reported bedtime snacks are usually passed between 7:00 p.m. to 8:00 p.m. A snack cart is usually kept at the nurse's station. Independent residents can get their own and the aides are supposed to take the snack cart to the residents who are not able to get their own snacks to their rooms. The nurses will document as such on the medication administration record.	F 809		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain facility doors in good repair. The facility reported a census of 28 residents.	F 921		

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Findings include:

1. Observations of the South Hall on 1/18/18 at 7:29 a.m. revealed the following concerns:

a. Pieces missing from the bottom door covering of the following rooms: soiled utility, 18, 19 , 22, 24 and 25.
b. Pieces missing from the doors of rooms 19 and 23.
c. The bottom door covering had separated from the door of Room 28.

During an interview on 1/18/18 at 7:42 a.m., the Environmental Services Supervisor stated the doors were an issue and were on the list to take care of.

2. Observation on 1/18/18 at 8:13 AM revealed the following concerns:

a. The fire door on the north hall showed heavy scratches over the surface.
b. The Bath/shower door on the north hall showed damage to the inner bottom edge which measured 6 by 5 inches.
c. Room #2 showed scarred wood at the bottom which measured 5 by 3 inches.
d. Room #3 had damage measuring 2 by 3 inches to the inner bottom of the door down to the wood.
e. Room #4 had damage to the inner bottom area measuring 6 by 4 inches.
f. Room #9 had damage to the inner bottom area measuring 8 by 4 inches.