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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZGKC11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2.STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LYNNHURST**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

4. TYPE OF ACTION: **9** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 03/08/2016 (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **72** (L18)

13.Total Certified Beds **72** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 04/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/06/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN: 24-5394

On March 8, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 along with the facility's plan of correction

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2939
March 29, 2016

****This letter redacts and replaces the letter dated March 25, 2016.****

Mr. Michael Carlson, Administrator
Golden Livingcenter - Lynnhurst
471 Lynnhurst Avenue West
Saint Paul, Minnesota 55104

RE: Project Number S5394028

Dear Mr. Carlson:

On March 8, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 17, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that the following remedy will be imposed:

- Per instance civil money penalty for the deficiency cited at F 314. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 8, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 8, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Received Via Secure Drop 4/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LYNNHURST	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(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 A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was conducted. The following deficiencies were issued.	F 000	F 000 Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

Accepted Plan of Correction 4-8-16

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

Executive Director | 4/8/16

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment for 3 of 10 residents (R9, R10, R5) in the sample who had a comprehensive completed. Findings include: R9 had an annual Minimum Data Set (MDS) completed on 10/6/15. The corresponding Care Area Assessments (CAAs) dated 10/14/15, were reviewed and the following was noted: - The Delirium CAA indicated R9 had pain along with pain frequency, intensity, and characteristics that could be indicative of delirium, and a recent decrease in eating habits. The CAA was a checklist and failed to evaluate how these factors specifically impacted R9's pain and decrease in eating. - The Cognitive Loss/Dementia CAA indicated R9 had delirium, Alzheimer's disease, confusion, indications of pain, a decline in continence, noted the resident had potential for more independence with cueing, restorative nursing program, and /or task segmentation. The CAA was a checklist and failed to evaluate how these factors specifically impacted R9's cognitive status or the rationale for the care planning decision especially with the indications of pain, the decline in ability to make self-understood, potential for more independence and decline in incontinence.	F 272	F 272 •R9 no longer resides in facility R5 and R10 have had triggered CAA's comprehensively assessed. •All residents have potential to be affected if triggered CAA's are not comprehensively assessed. RNAC to assure that RAI is used in accordance with resident's comprehensive assessment as part of ongoing process to identify resident's functional capacity and health status. •RNAC has been educated on comprehensive assessment of triggered CAA's. •DNS/designee to complete random weekly audits on 10 comprehensive MDS's for accuracy of CAA notes in MDS. Results of these audits will be reviewed by QAPI. •DNS/designee is responsible. •Completion date is 4-17-16	

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F 272	Continued From page 2 - The Activities of Daily Living (ADL) CAA indicated R9 had changing cognitive status, pain, daily behavior symptoms, mood decline, weight loss, depression and a recent hospitalization. The care plan decision was to slow or minimize the decline and maintain current functioning. However, there was no documentation as to how the facility was going to meet R9's need and there was not a referral to another discipline if needed to assist R9 in maintaining function. - The Behavioral Symptoms CAA was void of any description that impacted the problem/need for the resident or the facility's rationale for care plan decision. For all of R9's CAAs the care plan decision was to proceed to care plan however, the overall objective was left blank with the exception of ADL CAA. The objectives included improvement, slow or minimize decline, avoid complications, maintain current level of functioning, minimize risks, and symptom relief or palliative measure. The Care Plan considerations section was void of any documentation that described the impact of the problem/need on the resident and the facility's rationale for care plan decision. The CAAs lacked documentation of assessment information. The CAAs also failed to identify who participated in the assessment, whether the resident was observed and participated, and if licensed and non-licensed staff participated as well. R10 had an annual MDS completed on 1/7/16. The CAAs dated 1/18/16, were reviewed and the following was noted: - The Cognitive Loss/Dementia CAA indicated R10 had Alzheimer's disease, a decreased ability to make self-understood, had indications of pain,	F 272		

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F 272	Continued From page 3 a decline in incontinence, noted the resident had potential for more independence with cueing, restorative nursing program, and /or task segmentation. The CAA was a checklist and failed to evaluate how these factors specifically impacted R10's cognitive status or the rationale for the care planning decision especially with the indications of pain, the decline in ability to make self-understood, potential for more independence and decline in incontinence. - The Psychosocial Well-being CAA indicated R10 had 'other dementia' (although Alzheimer's was noted under Cognitive Loss, it was not checked for that CAA), aphasia, depression, and a change in communication. The CAA was a checklist and failed to evaluate how these factors specifically impacted R10's cognitive status or the rationale for the care planning decision especially with the change in communication and the 'other dementia'. - The Activities CAA and Pressure Ulcer CAA were void of any description that impacted of the problem/need on the resident and the facility's rationale for care plan decision. For all of R10's CAAs the care plan decision was to proceed to care plan however, the overall objectives were left blank. The objectives included improvement, slow or minimize decline, avoid complications, maintain current level of functioning, minimize risks, and symptom relief or palliative measure. The Care Plan consideration section was void of any documentation that described the impact of the problem/need on the resident and the facility's rationale for care plan decision. The CAAs lacked documentation of assessment information or any documented reference as to where information relating to the CAAs could be located. The CAAs failed to	F 272		

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F 272	Continued From page 4 identify who had participated in the assessment, whether the resident was observed and participated, and whether licensed and non-licensed staff participated as well. R5's annual MDS with ARD (assessment reference date) of 12/29/15. The CAAs dated 1/12/16, were reviewed and the following was noted: - The Delirium, Communication, ADL (activities of daily living), Urinary Incontinence and Indwelling Catheter, Falls, Dental, Pressure Ulcer and Psychotropic drug use CAAs had all triggered for additional review however they were void of any description facility's rationale for care plan decision. Furthermore, the overall objectives were left blank, the CAAs lacked documentation of assessment information, and documentation where the information relating to the CAAs could be located. The CAAs also lacked who participated in the assessment if the resident was observed and participated and if licensed and non-licensed staff participated as well. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, described the CAA process as follows: "Documentation for each triggered CAA should describe: The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what is the problem for this resident? Causes and contributing factors. Complications affecting or caused by the care area for this resident. Risk factors that arise because of the presence of the condition that affect the staff 's decision to proceed to care planning.	F 272		

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F 272	Continued From page 5 Factors that must be considered in developing individualized care plan interventions, including appropriate documentation to justify the decision to plan care or not to plan care for the individual resident. Need for referrals or further evaluation by appropriate health professionals. What research, resource(s), or assessment tool(s) were used in performing the CAA. A source(s) need only be cited if it is not already cited as the standard source(s) used for this CAA by facility policy."	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	F 278 •R 1, and R10 MDS updated to reflect changes not accurately coded. •All residents have potential to be affected if MDS is not accurately coded. •RNAC has been educated on RAI criteria for coding of UTI's and catheters. •Random audits of 10 MDS's of section "H" will be completed. Results of these audits will be reviewed by QAPI. •DNS/designee is responsible. Completion date is 4-17-16	

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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 278	Continued From page 6 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 10 residents (R1, R10) reviewed for indwelling catheter and/or urinary tract infection (UTI). Findings include: Indwelling catheter: R1's quarterly MDS dated 1/28/16, reflected R1 had an active diagnoses of neurogenic bladder however, did not identify R1's use of an indwelling catheter. A Physician's Order dated 2/2/16, indicated R1 required use of a Foley (indwelling) catheter which should be changed every month. The order included, "dx: (diagnosis) neurogenic bladder (a bladder dysfunction caused by a neurological condition)." R1's Comprehensive Assessment Note dated 2/24/16, identified the use of an indwelling catheter related to urinary retention, and indicated R1 had a diagnosis of neurogenic bladder. On 3/8/16, at 7:30 p.m. nursing assistant (NA)-A stated R1 had utilized an indwelling catheter "for a while now." NA-A indicated R1 received catheter care in the morning and evening, and required staff assistance with switching from a	F 278		

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	245394	A. BUILDING _____ B. WING _____	03/08/2016

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F 278	Continued From page 7 closed drainage bag used at night, to a leg bag used during the day. On 3/8/16, at 11:24 a.m. registered nurse (RN)-B stated R1's indwelling catheter had been initiated 8/17/15. RN-B acknowledged she had mis-coded the MDS and had not included R1's indwelling catheter use. RN-B further stated, "We are actually losing money from my not coding it right." On 3/8/16, at 1:13 p.m. the director of nursing services stated she expected all resident MDS assessments to be coded accurately to reflect each resident's current status and needs. According to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 dated last revised on October 2015, the intent of the items in the bladder section was to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. "Each resident who was incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible." In addition the facility was follow the Steps for Assessment which included: "1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances." UTI:	F 278		

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F 278	Continued From page 8 R10's annual MDS dated 1/7/16, was inaccurately coded for UTI. The 1/7/16 annual MDS indicated R10 had experienced an UTI within the last 30 days. The Progress Notes were reviewed from 1/7/16, going back 30 days and the following was noted: - On 1/5/16, R10 was sent to the emergency room to have a gastrostomy/jejunosotmy (G/J) tube changed and while R10 was there, the hospital also changed the resident's indwelling catheter. - On 1/7/16, the hospital called the facility and informed the facility R10 had an UTI and R10 on started on an antibiotic. Although the facility updated R10's primary physician on that day, the medical record lacked evidence of any assessment for signs and symptoms reflecting the UTI to determine whether the antibiotic was necessary. R10's medical record lacked evidence of any signs or symptoms of a documented UTI such as a fever, or change in the resident's status. On 3/8/16, at 11:05 a.m. the director of nursing was interviewed and she acknowlegded the medical record lacked evidence of signs and symptoms of a UTI. The DON stated she would expect staff to follow up with the primary physician to determine whether the antibiotic was clinically indicated since R10 displayed no signs or symptoms of infection including fever or change in status. On 3/8/16, at 11:33 a.m. RN-D reviewed R10's record with the surveyor and verified the MDS had been inaccurately coded. RN-D stated the UTI should not have been coded on the MDS. She further stated she came from the "old school"	F 278		

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F 278	Continued From page 9 where nurses did not question the doctors, although she was aware of the potential for overuse of antibiotics. The facility's policy for UTIs dated 8/14, directed the staff and practitioner to identify residents with signs and symptoms suggesting the possibility of UTIs. The staff were to follow the Surveillance definitions of Infections of Long Term Care for criteria that defines UTIs. "Clinical definitions of a UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team." According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, UTIs can only be coded on the MDS when all of the following criteria are met: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnose a UTI in last 30 days, 2. Signs or symptoms attributed to UTI, may or may not include but are not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria), 3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and 4. Current medication or treatment for a UTI in the last 30 days.	F 278		

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F 279	Continued From page 10	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care related to antipsychotic medication for 1 of 2 residents (R8) reviewed for psychotic medications Findings include: R8's care plan dated 9/25/15, identified R8 received an antidepressant medication related to depression. The care plan did not identify olanzapine as an antipsychotic medication and lacked direction for staff to monitor for side	F 279	F279 •Resident 8 care plan reviewed and updated to include antipsychotic usage. •All residents on antipsychotics have the potential to be affected if care plans are not developed to address antipsychotic use. •RNAC has been Educated on developing plan of care for residents receiving antipsychotic medication. •DNS/designee to complete random weekly audits of care plan to ensure antipsychotic usage is addressed for proper monitoring. Results of these audits will be reviewed by QAPI •Completion date is 4-17-16	

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F 279	Continued From page 11 effects, orthostatic blood pressure and/or target behaviors. The care plan also failed to identify non-pharmacological interventions to be utilized. The Physician Orders dated 3/8/16, indicated R8 had an order for olanzapine 5 milligrams (mg) by mouth two a day. R8's Medication Administration Record (MAR) for December 2015, and January, February and March 2016, indicated R8 received olanzapine. On 3/8/16, at 9:17 a.m. registered nurse (RN)-C confirmed the care plan lacked side effect monitoring, orthostatic blood pressure, non-pharmacological interventions and target behavior monitoring for use of antipsychotic medication. RN-C indicated further verified she would expect use of antipsychotic medications to be included on the care plan. On 3/8/16, at 9:17 a.m. RN-D verified the care plan lacked interventions for side effect monitoring, orthostatic blood pressure, non-pharmacological interventions and target behavior monitoring related to the use of the antipsychotic medication. RN-D further acknowledged R8 had received olanzapine during the assessment reference dates of 1/5/16 and 1/26/16. RN-D stated, "I will update the care plan, my expectation is care plans should be updated as necessary." The facility's policy and procedure titled Interdisciplinary Care Plan 2/26/15, included: "The social service staff will communicate mental and psychosocial problems, needs, and concerns to the interdisciplinary team for inclusion in the care plan. They will include: Areas triggered on	F 279		

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F 279	Continued From page 12 the MDS (Minimum Data Set) and identified on the RAP (Resident Assessment Protocol) Summary as proceed to the care plan ..."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 observation, interview and document review, the facility failed to provide repositioning according to each resident's individualized plan of care for 2 of 4 residents (R2, R4) in the sample identified at risk for pressure ulcers. Findings include: During an interview regarding R2's skin, on 3/8/16 at 7:46 a.m., licensed practical nurse (LPN)-A stated R2 had a foam dressing in place over a pressure ulcer. During an observation on 3/8/16 at 8:04 a.m., RN-A and LPN-A entered R2's room to provide care to the resident's coccyx wound. RN-A stated he had last measured the wound on Friday 3/4/16, at which time R2 had only one wound. RN-A measured the original wound as 2.3 centimeters (cm) x 2.0 cm x 0.2 cm and described it as an irregular stage II with a wound bed covered by 90% yellow necrotic tissue with 10% granulating tissue. RN-A then went on to measure the newly acquired stage II pressure	F 282	F282 •Resident 2 and resident 4 are being repositioned according to individual plan of care •All residents at risk for pressure ulcers have the potential to be affected if repositioning does not occur according to care plan •Education to staff on cares being given per care plan and importance of repositioning to prevent breakdown. •DNS/designee to complete random weekly audits of repositioning being provided according to care plan. •Results of these audits will be reviewed by QAPI Completion date is 4-17-16	

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F 282	Continued From page 13 area located on the inferior of the coccyx. The new area was measured as 0.4 cm x 0.8 cm x 0.1 cm. RN-A described the wound bed as being covered with yellow necrotic tissue with defined edges. RN-A and LPN-A verified they had been unaware of the new wound and that no staff had reported the presence of the second wound. Consequently, the new wound had not been assessed. At 8:25 a.m. the nurses repositioned R2 to his back and left the room. On 3/8/16, at 8:27 a.m. RN-A stated he expected the nursing assistants who provided daily care, to immediately report all skin concerns to the nurse so that an assessment could be done. RN-A again acknowledged the new open area next to the existing coccyx wound had not been assessed and identified. RN-A stated R2 required total physical assistance with all cares including incontinence cares, turning and repositioning so he would have expected someone to have seen the concern and reported it. On 3/8/16, at 9:00 a.m. R2 was observed seated in a wheelchair at the dining room. R2's wheelchair was observed to tilted slightly backwards. At 9:41 a.m. LPN-A was observed to wheel R2 to the bedroom and to leave again. At 10:38 a.m. NA-C and NA-B were observed to leave R2's room after having transferred R2 to her bed, where she was positioned on her back. During interview with NA-A at 10:42 a.m. on 3/8/16, he stated he had assisted NA-C to lay R2 down in bed at about 10:25 a.m. NA-B was interviewed immediately after NA-A and stated he did not work with R2 however, NA-B stated R2 was supposed to be repositioned every one hour.	F 282		

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F 282	Continued From page 14 During interview with LPN-A at 10:44 a.m. on 3/8/16, LPN-A stated, "We got her up around 8:30 a.m" (Indicating resident had been up 1 hour and 55 minutes without repositioning). When asked how often resident was supposed to be repositioned, LPN-A stated every hour. LPN-A verified R2 had been identified at risk for pressure ulcers and had an actual pressure ulcer on the coccyx. LPN-A also verified R2 had not received assistance to reposition as required. At 10:48 a.m. LPN-A stated she expected the NA's to follow all residents' care plans, to report any concerns about residents' skin, and to report when they were running late with repositioning residents. LPN-A also stated the NA's needed to report issues with running late immediately so she could get help to reposition R2 since she had an open area. R2's pressure ulcer Care Area Assessment (CAA) dated 10/8/15, identified R2 as having a potential for impaired skin integrity related to incontinence of bowel and bladder, dependence on staff for changing and pericare, and as requiring extensive assistance with bed mobility, turning, repositioning and off-loading. The CAA also indicated R2 was at risk for pressure ulcer development per the Braden Score. R2's Minimum Data Set (MDS) dated 12/23/15, identified diagnoses including hemiplegia, hemiparesis, type II diabetes, idiopathic peripheral neuropathy, and dementia. The MDS indicated R2 did not have any unhealed pressure ulcers and identified R2 as at risk for developing pressure ulcers. R2's care plan dated 1/4/16, indicated R2 had the potential for impaired skin integrity related to total	F 282		

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F 282	Continued From page 15 assistance with bed mobility, turning and repositioning, off-loading and transfers. The goal included: "Skin will remain free from breakdown." Care plan interventions directed staff to conduct daily observation of R2's skin with all cares, report alterations to nurse, nurse to conduct weekly skin inspection, treatments as ordered, and to turn and reposition the resident every hour and as needed due to open area. During review of the Progress Notes from 1/16/16 through 3/7/16, revealed the following: - On 1/16/16, indicated resident had ongoing pink, scar tissue area on coccyx... - On 2/13/16, indicated resident had ongoing compromised area on the coccyx which was slightly red and cream was applied as ordered. - On 2/27/16, indicated resident skin was assessed, the compromised area on coccyx was open, area measured 1.0 cm x 1.4 cm, wound bed was 100% granulated with macerated edges and peri-wound was pink. In addition, the note indicated pink areas had been noted to both buttocks with potential for opening. The note further indicated the open wound had been cleansed and a foam dressing had been applied. - On 3/7/16, indicated the pressure related wound on the coccyx measured 3.0 cm x 2.0 cm x 0.0 cm. Wound bed was 100% yellow slough, edges were undefined and macerated. An undated nursing assistant Second Floor Group B assignment sheet, a component of the plan of care, directed staff to "Reposition every one hour until buttocks healed." On 3/8/16, at 11:16 a.m. the director of nursing (DON) pulled up an assessment dated 3/4/16, which indicated R2 had only one wound on the	F 282		

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F 282	Continued From page 16 coccyx. The DON stated she expected the nurse to conduct weekly skin assessments and to ensure the assessments were accurate. She also stated she expected staff to provide care in accordance with individual resident's care plans, and to report any concerns including skin issues, to the nurse who would then be expected to conduct an assessment. On 3/8/16, at 12:14 p.m. RN-B, the MDS coordinator, was interviewed and stated "we watch her (R2) closely because of the history of the area re-opening." RN-B also verified R2 was supposed to be repositioned every hour as directed by the care plan. On 3/8/16, at 4:13 p.m. RN-A stated he'd verified the coccyx wound had increased in size from 2/27/16 to 3/4/16. R4 was continuously observed on 3/8/16, from 7:36 a.m. to 9:38 a.m. lying in bed on his back with the bead elevated approximately 45 degrees. R4 was interviewed at 9:38 a.m. and was asked whether staff had assisted him with morning cares, R4 nodded and stated "yes." At 9:40 a.m. on 3/8/16, NA-B was interviewed and stated he was assigned to R4 for the shift. When asked when R4 had last been repositioned, NA-B stated NA-A had repositioned R4 around 7:30 a.m. At 9:50 a.m. on 3/8/16, NA-A and NA-B entered R4's room, and asked the resident if he wanted to get up, R4 declined. At 9:52 a.m. on 3/8/16, the NA's were observed to reposition R4. No pillows were observed to have	F 282		

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F 282	Continued From page 17 been in place behind R4's back. The NAs slid R4 up in the bed and turned the resident from the right to the left, and then positioned R4 on the back again. NA-B elevated the bed at approximately 45 degrees. At 9:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been offered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, breakfast had been served late that morning, and that he had been assisting residents who smoked in the smoking room. R4 was observed on 3/8/16 again from 9:57 a.m. to 10:39 a.m., R4 remained on his back as he slept. At 10:39 a.m. on 3/8/16, LPN-A verified R4 was lying on his back and verified the Second Floor Group C assignment sheet, a component of the plan of care, directed "Keep pressure off coccyx." LPN-A stated R4 was supposed to be turned from side to side as the resident was at risk for pressure ulcers. LPN-A stated she was going to find an NA to turn R4 to his side. At 10:48 a.m. LPN-A stated she would have expected the NA's to follow R4's care plan and to have reported to her immediately if they were not able to reposition resident timely as resident was at a high risk for pressure ulcers. At 10:55 a.m. NA-A stated he was aware R4 was supposed to be repositioned side to side but had thought NA-B was going to put a pillow behind the resident after he had assisted NA-B to reposition R4 at 9:52 a.m. R4's Pressure Ulcer CAA dated 1/8/16, indicated R4 was at risk for the development of pressure ulcers due to multiple sclerosis,	F 282		

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F 282	Continued From page 18 hemiplegia/hemiparesis, incontinence, immobility, cognitive loss, and delirium that limited mobility. R4's care plan revised 3/7/16, identified resident had potential for impaired skin integrity, was at risk for pressure ulcers related to requiring extensive assist with bed mobility, turning and repositioning and being incontinent of both bowel and bladder. The care plan identified also R4 had a history of open areas, had confounding diagnoses for traumatic brain injury, multiple sclerosis and left sided hemiplegia. The care plan directed "Nurse to conduct weekly skin inspection, turn and reposition every two hours and as needed when in bed." R4's Physician Order dated 3/8/16, indicated resident wound orders as "Foam dressing to coccyx, denuded (a loss of some or all of the epidermis (the outer layer) leaving a denuded surface area). Change daily and when soiled." During review of the interdisciplinary progress notes, and Weekly Skin Reviews dated 2/1 to 3/7/16, it was revealed that on 2/14, 2/28 and 3/7/16, documentation indicated R4 had an ongoing denuded area on the coccyx. In addition, the Wound Evaluation Flow sheet dated 3/7/16, indicated the denuded coccyx area had been identified as a Stage 2 pressure ulcer. On 3/8/16, at 1:15 p.m. the DON stated she expected the NA's to follow each resident's plan of care to provide resident care. On 3/8/16, at 2:23 p.m. RN-A stated staff were supposed to check each resident's skin weekly. RN-A stated, "they are supposed to do it and sign off on the MAR [Medication Administration	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	03/08/2016

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F 282	Continued From page 19 Record]." When asked for a description of the denuded area, RN-A stated the top layer of the skin was gone and was covered with a white covering/coat. The undated Skin Integrity Guideline indicated the treatment protocol goals for stage I, reddened and denuded areas were to protect from pressure, moisture and prevent further injury. The guideline indicated licensed nurses were responsible for performing a skin evaluation/observation weekly utilizing the Weekly Skin Review. In addition, the guideline indicated if a resident had been identified with a decline in skin integrity the care plan was to be implemented and followed. The undated Skin Integrity Guideline indicated the treatment protocol goals for stage I, reddened and denuded areas were to protect from pressure, moisture and prevent further injury. The guideline indicated licensed nurses were responsible for performing a skin evaluation/observation weekly utilizing the Weekly Skin Review UDA (facility wound form). In addition, the guideline indicated if a resident had been identified with a decline in skin interity the	F 282		

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F 282	Continued From page 20 care plan was to be implemented and followed.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and identify risk factors in order to prevent further skin breakdown following identification of pressure ulcers for 3 of 4 residents (R2, R4, R9) reviewed. In addition, the facility failed to provide care, and failed to determine whether current treatment was effective to promote healing, for current stage II pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) for 1 of 4 residents (R2). R2 sustained actual harm when the resident developed multiple and/or recurring stage II pressure ulcer on the coccyx. Findings include: On 3/8/16 at 7:30 a.m., nursing assistant (NA)-C was observed to be assisting R2 with morning	F 314	F314 •R 9 no longer resides in the facility, R 2 and R4 have been comprehensively assessed and risk factors identified to prevent further breakdown. Wound UDA system and interventions to monitor skin in place to assure issues are timely recognized, assessed, and reported to practitioner, nurse, and physician to be addressed. Weekly wound rounds to be done per facility protocol. •All residents at risk for skin breakdown have the potential to be affected if not assessed, risk factors identified, and interventions implemented to prevent further breakdown •Education completed to nursing staff on identifying residents at risk for skin breakdown and interventions for prevention and healing. •DNS/designee to complete random weekly audits to ensure skin checks and wound documentation are completed, care is being provided per care plan. •DNS is responsible. •Results of these audits will be reviewed by QAPI •Completion date is 4-17-16	

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F 314	Continued From page 21 cares. On 3/8/16 at 7:46 a.m., licensed practical nurse (LPN)-A stated R2 had a foam dressing in place over a pressure ulcer. LPN-A stated the dressing was being changed three times a week (Monday, Wednesday and Friday) but that she had placed a call to the nurse practitioner (NP) to get orders to change the current treatment because she felt the wound, which was on the resident's coccyx, could use additional treatment. LPN-A also stated she was waiting for registered nurse (RN)-A, the nurse manager, to assess the wound's progress because RN-A was the nurse who provided wound care on the unit. During an observation on 3/8/16 at 8:04 a.m., RN-A and LPN-A entered R2's room to provide care to the resident's coccyx wound. Both staff wore gloves during the observation. When RN-A spread the skin around the coccyx, two wounds were observed. RN-A stated he had last measured the wound on Friday 3/4/16, at which time R2 had only one wound. RN-A measured the original wound as 2.3 centimeters (cm) x 2.0 cm x 0.2 cm and described it as an irregular stage II with a wound bed covered by 90% yellow necrotic tissue with 10% granulating tissue. RN-A also stated the wound edges were macerated. RN-A then went on to measure the newly acquired stage II pressure area located on the inferior of the coccyx. The new area was measured as 0.4 cm x 0.8 cm x 0.1 cm. RN-A described the wound bed as being covered with yellow necrotic tissue with defined edges. RN-A and LPN-A verified they had been unaware of the new wound and that no staff had reported the presence of the second wound. Consequently, the new wound had not been assessed. At 8:16 a.m., LPN-A was	F 314		

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F 314	Continued From page 22 overheard indicating the nurse practitioner (NP) had ordered Hydrogel (a dressing that provides an ideal environment for cleaning the wound and allowing the body to rid itself of necrotic tissue) to be applied to the wound, and to cover it with a clear dressing. At 8:18 a.m. LPN-A left the room and RN-A was observed take the Q-tip (cotton tipped applicator) he had used to measure the wound depths, applied a pea size of Hydrogel to the wound bed and edges, then applied a clear dressing over the large wound. RN-A was not observed to have cleansed the wounds prior to the application of the Hydrogel. At 8:19 a.m. LPN-A returned to the room, applied a pair of gloves, removed the dressing RN-A had just applied, cleansed the wound with wound cleanser, applied a small amount of Hydrogel, then applied a new clear dressing over both wounds. At 8:25 a.m. the nurses repositioned R2 to his back and left the room. On 3/8/16, at 8:27 a.m. RN-A stated he expected the nursing assistants who provided daily care, to immediately report all skin concerns to the nurse so that an assessment could be done. RN-A again acknowledged the new open area next to the existing coccyx wound had not been assessed and identified. RN-A stated R2 required total physical assistance with all cares including incontinence cares, turning and repositioning so he would have expected someone to have seen the concern and reported it. On 3/8/16, at 9:00 a.m. R2 was observed seated in a wheelchair at the dining room. R2's wheelchair was observed to tilted slightly backwards. At 9:41 a.m. LPN-A was observed to wheel R2 to the bedroom and to leave again. At 10:38 a.m. NA-C and NA-B were observed to	F 314		

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F 314	Continued From page 23 leave R2's room after having transferred R2 to her bed, where she was positioned on her back. During interview with NA-A at 10:42 a.m. on 3/8/16, he stated he had assisted NA-C to lay R2 down in bed at about 10:25 a.m. NA-B was interviewed immediately after NA-A and stated he did not work with R2 however, NA-B stated R2 was supposed to be repositioned every one hour. During interview with LPN-A at 10:44 a.m. on 3/8/16, LPN-A stated, "We got her up around 8:30 a.m" (Indicating resident had been up 1 hour and 55 minutes without repositioning). When asked how often resident was supposed to be repositioned, LPN-A stated every hour. LPN-A verified R2 had been identified at risk for pressure ulcers and had an actual pressure ulcer on the coccyx. LPN-A also verified R2 had not received assistance to reposition as required. At 10:48 a.m. LPN-A stated she expected the NA's to follow all residents' care plans, to report any concerns about residents' skin, and to report when they were running late with repositioning residents. LPN-A also stated the NA's needed to report issues with running late immediately so she could get help to reposition R2 since she had an open area. R2's pressure ulcer Care Area Assessment (CAA) dated 10/8/15, identified R2 as having a potential for impaired skin integrity related to incontinence of bowel and bladder, dependence on staff for changing and pericare, and as requiring extensive assistance with bed mobility, turning, repositioning and off-loading. The CAA also indicated R2 was at risk for pressure ulcer development per the Braden Score.	F 314		

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F 314	Continued From page 24 R2's Minimum Data Set (MDS) dated 12/23/15, identified diagnoses including hemiplegia, hemiparesis, type II diabetes, idiopathic peripheral neuropathy, and dementia. The MDS further indicated R2 had severely impaired cognitive skills, and had both short and long term memory problems, requiring total to extensive physical assistance of one to two staff with all activities of daily living including transferring, toileting, personal hygiene and bed mobility. In addition, the MDS indicated R2 did not have any unhealed pressure ulcers and identified R2 as at risk for developing pressure ulcers. R2's care plan dated 1/4/16, indicated R2 had the potential for impaired skin integrity related to total assistance with bed mobility, turning and repositioning, off-loading and transfers. The goal included: "Skin will remain free from breakdown." Care plan interventions directed staff to conduct daily observation of R2's skin with all cares, report alterations to nurse, nurse to conduct weekly skin inspection, treatments as ordered, and to turn and reposition the resident every hour and as needed due to open area. During review of the Progress Notes from 1/16/16 through 3/7/16, revealed the following: - On 1/16/16, indicated resident had ongoing pink, scar tissue area on coccyx... - On 2/13/16, indicated resident had ongoing compromised area on the coccyx which was slightly red and cream was applied as ordered. - On 2/27/16, indicated resident skin was assessed, the compromised area on coccyx was open, area measured 1.0 cm x 1.4 cm, wound bed was 100% granulated with macerated edges and peri-wound was pink. In addition, the note indicated pink areas had been noted to both	F 314		

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F 314	Continued From page 25 buttocks with potential for opening. The note further indicated the open wound had been cleansed and a foam dressing had been applied. - On 3/7/16, indicated the pressure related wound on the coccyx measured 3.0 cm x 2.0 cm x 0.0 cm. Wound bed was 100% yellow slough, edges were undefined and macerated. An undated nursing assistant Second Floor Group B assignment sheet, directed staff to "Reposition every one hour until buttocks healed." On 3/8/16, at 11:16 a.m. the director of nursing (DON) pulled up an assessment dated 3/4/16, which indicated R2 had only one wound on the coccyx. The DON stated she expected the nurse to conduct weekly skin assessments and to ensure the assessments were accurate. She also stated she expected staff to provide care in accordance with individual resident's care plans, and to report any concerns including skin issues, to the nurse who would then be expected to conduct an assessment. On 3/8/16, at 12:14 p.m. RN-B, the MDS coordinator, was interviewed and stated "we watch her (R2) closely because of the history of the area re-opening." RN-B also verified R2 was supposed to be repositioned every hour as directed by the care plan. On 3/8/16, at 2:51 p.m. RN-A stated he had last assessed the wound on the coccyx on Friday 3/4/16. RN-A stated nurses were supposed to assess the area as indicated in Progress Notes dated 1/16/16, 2/13/16, and 2/27/16. Each of these progress notes had identified redness/pink areas and did not include more specific information related to the state of the area.	F 314		

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F 314	Continued From page 26 On 3/8/16, at 4:13 p.m. RN-A stated he'd verified the coccyx wound had increased in size from 2/27/16 to 3/4/16. R4 was continuously observed on 3/8/16, from 7:36 a.m. to 9:38 a.m. lying in bed on his back with the bead elevated approximately 45 degrees. R4 was interviewed at 9:38 a.m. and was asked whether staff had assisted him with morning cares, R4 nodded and stated "yes." At 9:40 a.m. on 3/8/16, NA-B was interviewed and stated he was assigned to R4 for the shift. When asked when R4 had last been repositioned, NA-B stated NA-A had repositioned R4 around 7:30 a.m. At 9:50 a.m. on 3/8/16, NA-A and NA-B entered R4's room, and asked the resident if he wanted to get up, R4 declined. At 9:52 a.m. on 3/8/16, the NA's were observed to reposition R4. No pillows were observed to have been in place behind R4's back. The NAs slid R4 up in the bed and turned the resident from the right to the left, and then positioned R4 on the back again. NA-B elevated the bed at approximately 45 degrees. At 9:57 a.m. on 3/8/16, NA-A and NA-B verified R4 had not been offered repositioning since 7:30 a.m., for a total of two hours and 22 minutes. NA-B stated NA-A had been on break, breakfast had been served late that morning, and that he had been assisting residents who smoked in the smoking room. R4 was observed on 3/8/16 again from 9:57 a.m.	F 314		

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F 314	Continued From page 27 to 10:39 a.m., R4 remained on his back as he slept. At 10:39 a.m. on 3/8/16, LPN-A verified R4 was lying on his back and verified the Second Floor Group C assignment sheet directed "Keep pressure off coccyx." LPN-A stated R4 was supposed to be turned from side to side as the resident was at risk for pressure ulcers. LPN-A stated she was going to find an NA to turn R4 to his side. At 10:48 a.m. LPN-A stated she would have expected the NA's to follow R4's care plan and to have reported to her immediately if they were not able to reposition resident timely as resident was at a high risk for pressure ulcers. At 10:55 a.m. NA-A stated he was aware R4 was supposed to be repositioned side to side but had thought NA-B was going to put a pillow behind the resident after he had assisted NA-B to reposition R4 at 9:52 a.m. R4's Pressure Ulcer CAA dated 1/8/16, indicated R4 was at risk for the development of pressure ulcers due to multiple sclerosis, hemiplegia/hemiparesis, incontinence, immobility, cognitive loss, and delirium that limited mobility. R4's care plan revised 3/7/16, identified resident had potential for impaired skin integrity, was at risk for pressure ulcers related to requiring extensive assist with bed mobility, turning and repositioning and being incontinent of both bowel and bladder. The care plan identified also R4 had a history of open areas, had confounding diagnoses for traumatic brain injury, multiple sclerosis and left sided hemiplegia. The care plan directed "Nurse to conduct weekly skin inspection, turn and reposition every two hours and as needed when in bed."	F 314		

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F 314	Continued From page 28 R4's Physician Order dated 3/8/16, indicated resident wound orders as "Foam dressing to coccyx, denuded (a loss of some or all of the epidermis (the outer layer) leaving a denuded surface area). Change daily and when soiled." During review of the interdisciplinary progress notes, and Weekly Skin Reviews dated 2/1 to 3/7/16, it was revealed that on 2/14, 2/28 and 3/7/16, documentation indicated R4 had an ongoing denuded area on the coccyx. In addition, the Wound Evaluation Flow sheet dated 3/7/16, indicated the denuded coccyx area had been identified as a Stage 2 pressure ulcer. On 3/8/16, at 1:15 p.m. the DON stated she expected the NA's to follow each resident's plan of care to provide resident care. On 3/8/16, at 2:23 p.m. RN-A stated staff were supposed to check each resident's skin weekly. RN-A stated, "they are supposed to do it and sign off on the MAR [Medication Administration Record]." When asked for a description of the denuded area, RN-A stated the top layer of the skin was gone and was covered with a white covering/coat. When asked if the nurses were supposed to measure the denuded area, RN-A stated he was going to check what the facility policy directed. When asked about R4's skin concern, RN-A verified again that R4 had a denuded area on his coccyx. When asked about the 3/7/16 wound documentation, RN-A stated he had assessed the area on 3/4/16, which was Friday then completed the documentation on Monday three days later. On 3/8/16, at 2:49 p.m. RN-A approached stated	F 314		

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F 314	Continued From page 29 he had looked over the wound documentation and thought he had made a mistake with the staging of the denuded coccyx area and provided the facility policy. The facility's undated Skin Integrity Guidelines, indicated the treatment protocol goals for stage I, reddened and denuded areas were to protect from pressure, moisture and prevent further injury. The guideline indicated licensed nurses were responsible for performing a skin evaluation/observation weekly utilizing the Weekly Skin Review. In addition, the guideline indicated if a resident had been identified with a decline in skin integrity the care plan was to be implemented and followed. R9 was not comprehensively reassessed to identify risk factors in order to prevent potential further skin breakdown, after a pressure ulcer was identified by staff on R9's buttocks on 3/8/16. R9's plan of care initiated on 11/12/14, for potential for skin integrity indicated R9 needed extensive assist for turning and repositioning, bed mobility, and was incontinent of bowel. R9 was to be turned and repositioned per assessment. "Offload [prevention of skin breakdown - to re-distribute pressure] on rounds when in chair, able to reposition while in bed." The care plan was updated on 3/8/16, to turn and reposition every one hour after the Stage 2 ulcer was identified. The pressure Ulcer CAA dated 10/14/15, indicated R9 was at risk for the development of pressure ulcers due to weight loss, bowel incontinence and needing assistance with bed mobility.	F 314		

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F 314	Continued From page 30 The Comprehensive Skin Assessment dated 2/24/16, noted R9 could sit in a chair and lie in bed for two hours. The untitled nursing assistant assignment sheet dated 3/4/16, directed the staff to off load the resident on rounds. R9's was observed on the afternoon on 3/7/16, at 11:40 a.m. and on 3/9/16, at 7:37 a.m. lying on his back in bed. On 3/8/16, at 8:23 a.m. the DON was interviewed and stated R9 had no open areas. On 3/8/16, at 10:45 a.m. NA-E was interviewed and stated R9 had a reddened bottom and the she had informed LPN-B of that today. At 10:50 a.m. LPN-B was interviewed and stated she'd looked at R9's bottom and the resident had a reddened coccyx that was blanchable. R9's coccyx was observed on 3/8/16, at 11:15 a.m. with the DON. At that time, the DON stated the resident had a Stage 2 pressure ulcer on the coccyx. The wound measured 0.8 cm x 0.3 x 0.1 cm. The wound bed was described as 80% slough and 20% granulation. NA-E, present in the resident's room during the observation, stated she had been in the room earlier, but she had not completely turned R9 over to look at the coccyx. The facility's policy for Pressure Ulcer Review effective 7/8/15, directed staff to ensure that a resident with a pressure ulcer received care and services to promote healing of the pressure ulcer. Staff were to assess the resident if the resident had skin breakdown and were to develop	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	03/08/2016

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F 314	Continued From page 31 interventions to promote healing.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall intervention and prevention techniques were implemented for 1 of 3 residents (R10) reviewed for accidents. Findings include: R10 was observed on 3/7/16, continuously from 11:40 a.m. through 12:10 p.m. R10's door to the room was wide open from the hallway. R10's bed was in the low position, the head of bed and knee was slightly elevated and R10 was pushing on the footboard with both feet. The right side of the footboard had swung away from the bed at an approximately 25 to 30 degree angle. Nursing assistant (NA)-D placed R9's tray in the room and did not notice R10's ill-repaired footboard. The administrator was walking passed the room and was notified of the bed in need of repair. NA-D was interviewed on 3/7/16, at 12:15 p.m. NA-D indicated they had been working for here for years and when asked if he knew R10's bed	F 323	F323 •Resident R10's bed footboard has been repaired. Resident rooms have been inspected and repairs completed as needed. •All residents have the potential to be effected if not provided a safe environment •Staff to be educated on system to identify issues as needing repair •Random weekly audits of 2 rooms per week to ensure any repairs have been completed. Quarterly room checks to inspect beds and other furnishings for proper operation and repair as needed. •ED/designee is responsible •Negative results of these audits/ inspections will be reviewed at the facility QAPI meeting for further recommendation.	4-7-16

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F 323	Continued From page 32 needed repair he indicated there were a "lot of beds here" that needed repair and he had reported them to corporate but the beds still did not get fixed. NA-D was unable to provide any more information on what beds were in need of repair when asked during the interview. R10's care plan dated 1/5/15, indicated R10 was at risk for falls due to unsteady sitting and standing balance and was an assist of two to transfer using a mechanical lift. A one page typed note undated and untitled was provided which indicated R10 had fallen from the bed on 6/8/15 and 9/2/15. Both falls were from the side of the bed and not the foot of the bed. The administrator was interviewed on 3/7/16, at 3:16 p.m. he indicated there was no work order that could be located for R10's bed. The administrator revealed a bolt had snapped off the footboard allowing the footboard to swing away from the bed. The administrator went onto to note that the foot and head boards are to be checked by the maintenance department at least quarterly. He commented R10's bed was last checked on 12/22/15. He acknowledged R10 did slide down in bed even with the knees elevated and put his feet on against the footboard.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 33 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate monitoring of an antipsychotic medication for 1 of 5 residents (R5) who used Seroquel (antipsychotic). In addition, the facility failed to ensure 1 of 3 residents (R10) who was asymptomatic did not receive anti-biotic with justification. Findings include: On 3/8/16, at 2:21 p.m. R5 was observed to be awake, seated in the wheelchair. When approached and interviewed regarding the medication, Seroquel, R5 indicated she did not notice or experience any side effects from the medication that currently taking and R5 was	F 329	F329 •Resident 5 orthostatic blood pressure monitoring has been implemented, and R10 is no longer receiving antibiotics. •All resident receiving medications have the potential to be affected if proper monitoring and justifications for medications are not in place. •Nursing staff have been educated on proper monitoring for residents receiving psychotropic, all nursing educated on surveillance criteria for antibiotic use. •DNS/designee to complete random weekly audits of psychotropic monitoring and necessity of antibiotic usage •DNS is responsible. •Negative results of these audits will be reviewed by QAPI •Completion date is 4-17-16	

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F 329	Continued From page 34 observed to be relaxed with no behaviors. R5's Physician Orders dated 2/2/16, R5 had diagnoses which included personality disorder, Bipolar disorder, major depressive disorder, and dementia. Furthermore, R5 had an order for Seroquel 25 mg by mouth in the morning and 75 mg by mouth at bedtime, which was started on 12/1/14. R5's care plan dated 1/19/16, identified R5 received an antipsychotic medication. The care plan did address the antipsychotic medication and direction for staff to monitor for side effects that include postural hypotension, and observe for behaviors. However, medical record lacked documentation of monthly orthostatic blood pressure monitoring. The MAR (Medication Administration Record) for December 2015, January 2016 and February 2016, indicated R5 received Seroquel 25 mg by mouth in the morning and 75 mg by mouth at bedtime. MAR for March 2016, indicated R5 received Seroquel 25 mg by mouth in the morning and 50 mg by mouth at bedtime. On 3/8/16, at 2:19 p.m. licensed practical nurse (LPN)-B confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and indicated, they do not have an order for it and that was the reason why it has not been done monthly. On 3/8/16, at 2:23 p.m. registered nurse (RN)-C verify R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and stated, "My expectation is monthly orthostatic blood pressure monitoring should be done and it	F 329		

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F 329	Continued From page 35 have not be done. If it have not been done pharmacy consultant could have recommend it." On 3/8/16, at 3:41 p.m. director of nursing confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." On 3/8/16 at 3:44 p.m. the consultant pharmacist stated, monthly orthostatic blood pressure monitoring is included in the side effect monitoring and assume that staff is monitoring it monthly, that was the reason why he did not recommend it. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. Policy and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/15, reads, "Review Nursing Notes for documentation of daily side effect monitoring and follow up to side effects." R10's Minimum Data Set (MDS) dated 1/7/16, indicated R10 had a UTI within the last 30 days. R10's Progress Notes were reviewed from 1/7/16, going back 30 days and the following was noted: - On 1/5/16, R10 was sent to the emergency room to have a gastrostomy/jejunosotmy (G/J) tube changed and while R10 was there, the hospital also changed the resident's indwelling catheter. - On 1/7/16, the hospital called the facility and informed the facility R10 had an UTI and R10 on started on an antibiotic. Although the facility	F 329		

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F 329	Continued From page 36 updated R10's primary physician on that day, the medical record lacked evidence of any assessment for signs and symptoms reflecting the UTI to determine whether the antibiotic was necessary. R10's medical record lacked evidence of any signs or symptoms of a documented UTI such as a fever, or change in the resident's status. On 3/8/16, at 11:05 a.m. the director of nursing was interviewed and she acknowlegded the medical record lacked evidence of signs and symptoms of a UTI. The DON stated she would expect staff to follow up with the primary physician to determine whether the antibiotic was clinically indicated since R10 displayed no signs or symptoms of infection including fever or change in status. On 3/8/16, at 11:33 a.m. RN-D stated she came from the "old school" where nurses did not question the doctors, although she was aware of the potential for overuse of antibiotics. The facility's policy for UTIs dated 8/14, directed the staff and practitioner to identify residents with signs and symptoms suggesting the possibility of UTIs. The staff were to follow the Surveillance definitions of Infections of Long Term Care for criteria that defines UTIs. "Clinical definitions of a UTI are resident-specific and require the aggregation of signs and symptoms, lab data and the clinical judgment of the interdisciplinary team."	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		

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F 356	Continued From page 37 a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. 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 observation, interview, and document review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift on 3/5, 3/6, and 3/7/16. In addition, the staff posting was not current for the census. This had the potential to affect visitors and all 68 residents residing in the facility.	F 356	F356 •Nursing staff hour's posted in accordance with regulations. •Education to staff on location and the requirements of posting and maintaining the daily posted nursing hours. •ED is responsible. •ED/designee to do random weekly audits of hours posting. •Negative results of these audits will be reviewed by QAPI •Completion date is 4-17-16	

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F 356	Continued From page 38 Findings include: During the initial tour on 3/7/16, at 8:05 a.m. the facility nursing staff posting on a wall was observed on the behind the nursing station. The posted nursing staff information was dated 3/4/16, and had a census of 68. During the random observations of the nursing staff posting forms posted on the wall behind the nursing station desk on 2/29/16, 3/1/16, 3/2/16, 3/3/16, and 3/4/16, however there was no nursing staff posting for 3/5/16, 3/6/16 and 3/7/16. During an interview with the medical record director on 3/7/16, at 8:05 a.m. the medical record director administrator confirmed the nursing staff hour posting was noted posted for 3/5/16, 3/6/16 and 3/7/16 and stated, "It should be posted daily." During the interview with the staffing coordinator on 3/7/16, at 9:32 a.m. the staffing coordinator indicated, "My expectation is nursing staff posting should be posted daily. The census was 68 when I left on Friday. There was a new admit on Saturday 3/5/16." During the interview with the executive director on 3/7/16, at 9:32 a.m. the executive director administrator stated, "My expectation is nursing staff posting should be posted daily." Policy and titled NURSING STAFF HOURS last review date 8/14/15, read, "Nursing staff hours will be posted in accordance with state and federal regulations in all facilities. The posting shall be in a clear and readable format and	F 356		

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F 356	Continued From page 39 posted in a prominent place readily accessible to residents and visitors."	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon the recommendations of the consultant pharmacist for appropriate monitoring of an antipsychotic medication for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings include: On 3/8/16, at 2:21 p.m. R5 was observed to be awake, seated in the wheelchair. When approached and interviewed regarding the medication, Seroquel, R5 indicated she did not notice or experience any side effects from the medication that currently taking and R5 was observed to be relaxed with no behaviors. R5's Physician Orders dated 2/2/16, R5 had diagnoses which included personality disorder,	F 428	F428 •Resident 5 monthly pharmacy review completed. •All residents have the potential to be affected if monthly pharmacy reviews are not completed per regulation. •DNS/designee to complete random audits to ensure residents receive monthly medication reviews. •DNS/Designee/Consulting pharmacist is responsible. •Negative results of these audits will be reviewed by QAPI •Completion date is 4-17-16	

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F 428	Continued From page 40 Bipolar disorder, major depressive disorder, and dementia. Furthermore, R5 had an order for Seroquel 25 mg by mouth in the morning and 75 mg by mouth at bedtime, which was started on 12/1/14. R5's care plan dated 1/19/16, identified R5 received an antipsychotic medication. The care plan did address the antipsychotic medication and direction for staff to monitor for side effects that include postural hypotension, and observe for behaviors. However, medical record lacked documentation of monthly orthostatic blood pressure monitoring. The MAR (Medication Administration Record) for December 2015, January 2016 and February 2016, indicated R5 received Seroquel 25 mg by mouth in the morning and 75 mg by mouth at bedtime. MAR for March 2016, indicated R5 received Seroquel 25 mg by mouth in the morning and 50 mg by mouth at bedtime. On 3/8/16, at 2:19 p.m. licensed practical nurse (LPN)-B confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and indicated, they do not have an order for it and that was the reason why it has not been done monthly. On 3/8/16, at 2:23 p.m. registered nurse (RN)-C verify R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and stated, "My expectation is monthly orthostatic blood pressure monitoring should be done and it have not be done. If it have not been done pharmacy consultant could have recommend it." On 3/8/16, at 3:41 p.m. director of nursing	F 428		

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F 428	Continued From page 41 confirmed R5's medical record lacked documentation of monthly orthostatic blood pressure monitoring and mentioned, "My expectation orthostatic blood pressure monitoring should be done." On 3/8/16 at 3:44 p.m. consultant pharmacist stated, monthly orthostatic blood pressure monitoring is included in the side effect monitoring and assume that staff is monitoring it monthly, that was the reason why he did not recommend it. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. Policy and procedure title ANTIPSYCHOTIC MEDICATION REVIEW dated 5/4/2015, reads, "Review Nursing Notes for documentation of daily side effect monitoring and follow up to side effects." Policy and procedure title MEDICATION MONITORING MEDICATION REGIMEN REVIEW dated 5/12, read, "The consultant pharmacist identifies irregularities through a variety of sources including: Medication Administration records (MARs); prescriber's orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following: ... 17. Side effects, adverse reactions, and interactions (drug-drug, drug-diet, drug-lab test and drug-disease) are evaluated, and modifications or alternatives are	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 42 considered."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 •R2 reassessed by wound care physicians and nurse manger. New orders put into place, and evaluated weekly. •All residents have the potential to be effected if infection control policies are not followed. •Reeducation to nursing staff on the facilities infection control policies and procedures. •DNS/designee to do random weekly audits to check for compliance during dressing change. •Negative results of these audits will be reviewed by QAPI. •Completion date is 4-17-16	

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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 441	Continued From page 43	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure nursing staff provided personal and wound care to minimize the risk of infection of a pressure ulcer for 1 of 1 resident (R2) reviewed for pressure ulcers.

Findings include:

R2's diagnoses included hemiplegia and hemiparesis, diabetes, dementia with behavioral disturbance, hypertension, and anxiety. The quarterly Minimum Data Set (MDS) dated 12/23/15, revealed R2 did not have a pressure ulcer however, the Wound Evaluation Flow Sheet Multiple Weeks dated 3/4/16, revealed R2 had one Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough).

On 3/8/16, at 8:04 a.m. both registered nurse (RN)-A and licensed practical nurse (LPN)-A entered R2's room donned gloves went to R2's bedside turned R2 to the side. At 8:06 a.m. RN-A was observed assess and measure the wounds. At 8:08 a.m. RN-A removed gloves left the room without washing hands, went out to the hallway by the nursing station opened the treatment cart, was observed going through the drawers looking for supplies. At 8:10 a.m. came back to room never washed hands applied another pair of gloves proceeded to measure the depth. At 8:15 a.m. removed gloves left the room never washed hands went to the hallway and was observed go through the treatment cart again. At 8:16 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	03/08/2016

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F 441	Continued From page 44 RN-A came back to room never washed hands applied another pair of gloves. LPN-A was overheard indicate R2's wound treatment had changed. LPN-A removed gloves never washed hands. RN-A was observed take the q-tip he had used to measure the depth, applied a pea size to the wound bed and edges then applied a clear dressing on the large wound never cleansed the area. At 8:19 a.m. LPN-A came back to room, applied a pair of gloves never washed hands, removed the dressing RN-A had just applied, then cleansed the wound with wound cleanser, applied a small amount of hydrogel, then got a new clear dressing lying on the bed applied it to both wounds, never changed gloves. LPN-A then retrieved to the bathroom washed hands and left the room. RN-A was observed reach out with R2's rectal area and used a wipe to clean soft consistancy stool and after tossing the wipe never changed gloves or washed hands. RN-A continued to stand at R2's bedside with the same gloves touch R2's bare skin around the thighs, clothing, bedding/linen, call light and remote control then removed the gloves. At 8:25 a.m. both observed reposition R2 and left the room. On 3/8/16, at 8:27 a.m. both acknowledged they never washed hands before and after removing gloves during the observation. Both indicated the facility policy was to wash hands with each glove change, before leaving a room, and between wound cares. On 3/8/16, at 9:16 a.m. the director of nursing services (DNS) stated she expected the staff to wash hands or use hand sanitizer between glove changes, before and after wound care, before and after pericare and anytime staff hands were soiled.	F 441		

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F 441	Continued From page 45 Handwashing/Hand Hygiene policy revised August 2014, directed: "7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after direct contact with residents; b. Before preparing and handling medications; c. Before performing any non-surgical invasive procedures;... f. Before handling clean or soiled dressings, gauze pads, etc.; g. After toileting or assisting residents with toileting, handling of urinals, bedpans, catheters, soiled linen, towels, wash cloths. f. Before and after smoking or eating. g. After coughing, sneezing, or blowing of nose and or assisting residents after coughing, sneezing and blowing of nose. h. After handling uncooked animal products, such as raw meat or fish. i. Before performing a resident care ADL [activities of daily living] procedure and after removal of gloves if worn..."	F 441		