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	355096	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/18/16 and completed on 07/21/16, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed resident record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide accommodation of individual needs for 1 of 9 sampled residents (Resident #3) observed in a wheelchair. Failure to ensure proper wheelchair positioning may result in pressure ulcers, falls, and discomfort. Findings include: Review of the facility policy titled "Repositioning - Chair-Bound or Wheelchair Resident" occurred on 07/21/16. This policy, revised March 2011, stated, ". . . Purpose . . . To provide comfort, support, and good body alignment . . . To prevent	F 246	1)Corrective action was accomplished for resident #3 by placing dycem in his wheelchair on 7/20/16. OT consult for wheelchair positioning will be completed prior to completion date. 2)All residents in wheelchairs have the potential to be affected. 3)Staff education of all nursing staff will be given at meeting on 8/17/16. QA of wheelchair positioning of all residents in a wheelchair will be completed prior to completion date and referrals made to OT for positioning as needed. 4)QA of proper wheel chair positioning will be performed by nursing staff on all residents in a wheel chair prior	8/25/16

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

Electronically Signed | 08/17/2016

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F 246	Continued From page 1 pressure sores . . . If a resident is observed to be sliding or leaning in chair demonstrating poor positioning, contact charge nurse for assessment. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoarthritis. A nurse's note, dated 05/20/16 at 12:49 p.m., stated, ". . . Pain: Resident noted to be sliding from his w/c [wheelchair] during lunch. Res. [resident] with [sic] repositioned. Moaning and facial grimacing noted . . . Tylenol adm [administered] per PRN [as needed] order. . . ." The current care plan stated, ". . . I'm at risk for falling because I receive a daily scheduled antidepressant & antianxiety med [medication] and PRN Antianxiety med, I have a dx [diagnosis] of dementia, hx [history] of falls, unsteady gait, balance problems which staff assist with stabilization and I am unaware of my own safety concerns at times. . . . Approach start date: 05/31/2016 . . . Dicem [sic] [a non-slip mat] to w/c to prevent sliding . . ." Observation on 07/18/16 at 4:06 p.m. showed two certified nursing assistants (CNAs) (#6 and #7) assisted Resident #3 into his wheelchair using a mechanical lift. Observation showed no dycem in place on the wheelchair. The resident slid down and forward in the wheelchair. The CNA's repositioned Resident #3 so he was sitting upright in his wheelchair. One CNA (#6) stated, "He always slides down anyway." Observations throughout the survey showed Resident #3's wheelchair lacked the dycem mat,	F 246	to completion date, monthly X1, and quarterly X3. QA will be reviewed by the QA coordinator.	

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F 246	Continued From page 2 and the resident frequently slid down and forward in his wheelchair. During an interview on 07/20/16 at 3:54 p.m., a CNA (#2) stated, "We boost him up but he always just slides back down." On the morning of 07/21/16, an administrative nurse (#1) stated Resident #3 did not have a recent wheelchair positioning assessment.	F 246		
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 assessment.	F 278		8/25/16

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's status for 2 of 9 sampled residents (Resident #4 and #5) coded with delusions and hallucinations. Failure to accurately assess Resident #4 and #5 regarding hallucinations and delusions and code the MDS correctly does not reflect the resident's current status and may affect the level of care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2015, page E-2 states, " E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather then the presence of a medical diagnosis. Check all that apply. *Check E0100A, hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. *Check E0100Z,	F 278	1)Corrective Action was accomplished by modifying and resubmitting MDSs with dates 10/5/15, 12/30/15, and 3/22/16 for resident #4 and dates 10/7/15 and 12/29/15 for resident #5. 2)All residents may be affected. 3)All MDSs with coding for presence of delusions and hallucinations were reviewed for accuracy and modified and resubmitted to state and federal data base. Personnel responsible for incorrect coding is no longer employed. Social Service Designee and MDS Coordinator will review the RAI manual instructions for section E on hallucination and delusions as education. 4)Eleven additional MDS were identified, modified, and resubmitted by 8/4/16. Education of SSD and MDS Coordinator on section E will be completed by completion date. Further QA of section E coding will be completed monthly X2 and quarterly X3 by the MDS Coordinator and reviewed by the QA Coordinator. Random QA of 1 quarterly MDS assessment and 1 comprehensive MDS assessment will be completed by DON prior to the completion date, monthly X2 and quarterly X3 and QA reviewed by Administrator.	

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F 278	Continued From page 4 none of the above: if no hallucinations or delusions were present in the last 7 days. " - Review of Resident #4's medical record occurred on all days of survey and included a diagnosis of dementia with lewy bodies. The significant change MDS, dated 12/30/15, identified hallucinations and delusions during the seven day assessment period. The resident's medical record lacked evidence to support the coding of hallucinations and delusions during the assessment period. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The significant change MDS, dated 12/29/15, identified delusions present during the seven day assessment period. The admission MDS, dated 10/07/15, identified delusions and hallucinations present during the seven day assessment period. Resident #5's medical record lacked evidence to support the coding of delusions and hallucinations during the assessment periods. During an interview on 07/19/16 at 3:15 p.m., an administrative nurse (#1) agreed the facility staff coded Resident #4 and #5's MDSs incorrectly.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		8/25/16

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F 280	Continued From page 5 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the care plan for 3 of 9 sampled residents (Resident #3, #4, and #8). Failure to review and revise the care plans limits staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #4's medical record occurred on all days of survey. Diagnosis included dementia, diabetes mellitus, a history of falls, and an open area to resident's right buttock. Observations during the survey identified a pressure relieving cushion to Resident #4's wheelchair, and a bed alarm on the resident's bed. The care plan failed to identify the use of a pressure relieving cushion and a bed alarm.	F 280	1)Corrective action was completed by reviewing and modifying residents #3, #4, and #8 care plans. 2)All residents have the potential to be affected. 3)Daily care plan reviews will continue. Education of all nursing staff on care plan revision was completed on 8/17/16 at staff meeting. QA will continue for discrepancy between care plan, CNA assignment sheets, and interventions in place regarding fall interventions, pressure relief interventions, and will be initiated on dietary assistive devices. 4)QA of 3 random care plans in their entirety will be completed prior to completion date, monthly X3, and quarterly X3. QA will be completed by nursing staff and reviewed by the QA coordinator.	

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F 280	Continued From page 6 - Review of Resident #8's medical record occurred on July 20-21, 2016. Diagnosis included dementia and history of falls. Observation on July 20-21, 2016 showed a chair alarm on Resident #8's wheelchair and on a recliner in the living room. The resident's care plan failed to identify the use of the chair alarm. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoarthritis. Observation of meals occurred on 07/19/16 at 12:07 p.m., 07/19/16 at 5:40 p.m., 07/20/16 at 10:16 a.m., and 07/20/16 at 12:10 p.m. Observation showed Resident #3 used silverware with built-up handles to assist him with eating. Resident #3's care plan stated, ". . . I require assistance with my cares because I cannot do them myself. I do refuse cares at times. Decline in adl's [activities of daily living] d/t [due to] non wt [weight] bearing status to [right] shoulder from implant dislocation. . . . Assist me with eating prn [as needed]. I have a nonskid mat under my plate and a plate guard to help maintain some independence with eating. . . ." Resident #3's care plan failed to identify the use of built-up silverware.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		8/25/16

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F 309	Continued From page 7 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 sampled resident (Resident #7) who received dialysis at another location. Failure to obtain an agreement with the dialysis provider which included all aspects of how the resident's care should be managed, may result in complications related to the residents' health and decrease her quality of life and well-being. Findings include: The American Nephrology Nurses' Association (ANNA) "Vascular Access Fact Sheet," dated 2013, stated: ". . . Caring for a Fistula or Graft [dialysis access site]: Good fistula or graft care will help maintain the patency of the vascular access. There are measures that can be taken to prevent clotting or infection to the access. Feel the 'thrill' or vibration of blood through the access, or use a stethoscope to listen to the 'bruit' or 'whoosh' of blood through the access and site rotation. The access should be kept clean and free of injury. Inspect the access for signs of infection, including pain, tenderness, swelling, and redness to the area. . . . The access needs to be protected from injury or restriction to prevent	F 309	1)Corrective action will be completed for resident #7 by adding care plan interventions of fistula assessments, BP not on R) side, and signing an agreement between Aurora Dialysis Unit and APHC. 2)All residents receiving dialysis may be affected. 3)Staff will be educated on care of dialysis fistulas, BPs, and agreement at staff meeting on 8/17/16. 4)QA of all dialysis resident's care plan, BPs, and agreement will be completed prior to completion date monthly X1, and quarterly X3.	

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clotting of the access. *Avoid tight clothing, jewelry, or pressure on the access area. . . . *Avoid lying on the access site when sleeping. *Do not allow blood to be drawn from the access arm. *Do not allow blood pressure to be taken in the access arm. . . ."

Review of Resident #7's medical record occurred on 07/20/16. Diagnoses included chronic kidney disease. Physician's orders included hemodialysis three days a week. The record failed to include an agreement or arrangement between the facility and the dialysis provider to ensure the coordination of safe care and services for Resident #7.

Resident #7's care plan stated, "Problem: I have a Dx [diagnosis] of Acute Renal Failure and Hypercalcemia. I receive hemodialysis 3x/week [three times a week] . . . Approach: *Assist me with my meds [medications] as ordered. *Dialysis as ordered. *Monitor me for increased: edema, wt [weight] and lethargy. VS [vital sign] fluctuation and abdominal pain. And report to CN/MD prn [charge nurse/medical doctor as needed]. *Obtain my Wt and VS as ordered. *Treatments as ordered."

The care plan failed to include the location of Resident #7's fistula, how to assess the fistula for abnormalities (trill and bruit), signs and/or symptoms of clotting or infection, and not to obtain blood pressures or blood draws on the same arm as the fistula.

An interview occurred on 07/20/16 at 4:00 p.m. with a certified nursing assistant (CNA) (#8). When asked if he/she performs blood pressure

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F 309	Continued From page 9 measurements on Resident #7 and if so, which arm. The CNA stated, "Yes, every night" on the resident's right arm because it's easier to get to and more comfortable for her. The CNA (#8) was unaware Resident #7 had a dialysis access site in her right arm. During an interview on 07/20/16 at 3:30 p.m., two administrative staff members (#1 and #14) stated they do not have an agreement with Resident #7's dialysis provider. The staff members verified the care plan developed by the facility does not include the necessary interventions to care for Resident #7's dialysis fistula.	F 309		
F 323 SS=E	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, record review, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure appropriate use of an assistive device to prevent accidents for 4 of 6 sampled residents (Resident #2, #4, #5, and #8). Failure to appropriately use a gait belt increased the risk for falls, pain, and injury to the residents. Findings include:	F 323	1)Corrective action for resident #2, #4, #5, and #8 will be completed by staff education on gait belts. 2)All residents have the potential to be affected. 3)A mandatory in-service for all nursing staff will be provided by Logan Herman, PT on 8/17/16 on proper gait belt use. 4)QA of proper gait belt use will be completed prior to completion date, weekly X4,monthly X2, and quarterly X3. QA will	8/25/16

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F 323	Continued From page 10 Review of the facility policy titled "Transferring and Positioning Residents-Moving and Transferring" occurred on 07/21/16. This policy, revised March 2011, stated, "Procedure: Assisting Resident from Bed to Chair/Wheelchair . . . A gaitbelt should be used to help support resident . . . Procedure: Assisting Resident from Wheelchair/Chair into Bed . . . Have resident place feet flat on floor and support resident with gaitbelt." Mary E. Stassi "Basic Nurse Assisting," Elsevier Saunders, Philadelphia, 2005, page 235-236, stated, ". . . Procedure Transferring the Patient From the Bed to a Chair or Wheelchair. . . 7. Place the transfer or gaitbelt around the patient's waist and secure . . . Make sure the belt is under the breasts when using with a female patient. . . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, Pearson Education, Inc., New Jersey, page 1054, states, . . ."Make sure the belt is pulled snugly around the client's waist and fastened securely. . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia. The current care plan stated, ". . . Assist me with transfers and locomotion . . . Provide me with assistive devices as needed. W/C [wheelchair for mobility." Observation 07/19/16 at 9:23 a.m. showed Certified Nursing Assistant (CNA) (#2) applied a gait belt around Resident #4's chest and under	F 323	be completed by nursing staff and reviewed by the QA coordinator.	

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her armpits. The CNA (#2) stated, "We can put it under her arms because it won't fit around her belly." The CNA (#2) then transferred the resident from the bed to a wheelchair.

Observation on 07/19/16 at 10:56 a.m. showed two CNAs (#2 and #4) transferred Resident #4 from a wheelchair to the bed with a gait belt across her chest and under her armpits.

- Review of Resident #8's medical record occurred 07/20/16. Diagnoses included dementia and a history of falls. The quarterly MDS, dated 05/09/16, identified extensive assistance of one person for transfers. Resident #8's care plan stated, "I have trouble with my mobility because I have . . . dementia. I use a FWW [front wheeled walker] and assist of 1 staff member to ambulate . . ." A nursing progress note, dated 07/20/16, stated, " Resid. [resident] is 1 assist with ADLS [activities of daily living] . . . She is assist of 1 with gaitbelt with transfers . . ."

Observation on 07/20/16 at 10:58 a.m. showed a CNA (#3) applied a gait belt loosely around Resident #8's waist and pivot transferred the resident to a recliner. During the transfer, the gait belt slid up the resident's back.

Observation on 07/20/16 at 3:15 p.m. showed two CNAs (#2 and #5) transferred Resident #8 from her wheelchair to a recliner using a gait belt. The gait belt loosened and slid up under resident's arm pits. The CNAs readjusted and tightened the gait belt and re-attempted the transfer. The gait belt loosened and slid up under the resident's armpits again.

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Observation on 07/20/16 at 3:42 p.m. showed two CNAs (#2 and #5) utilized a gaitbelt and transferred Resident #8 from a recliner to a wheelchair. The gaitbelt was loosened and slid up the resident's back.

Observation on 7/20/2016 at 3:46 p.m. showed two CNAs (#2 and #5) utilized a gaitbelt and transferred Resident #8 from a wheelchair to a recliner. The gaitbelt was loosened and slid up to the resident's back.

The CNAs failed to tighten and/or readjust Resident #8's gaitbelt during the above transfers.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoarthritis, and a history of falls. The quarterly MDS, dated 06/29/16, identified severely impaired cognition and required extensive assistance of two people for transfers.

Resident #5's current care plan stated, "Problem . . . at risk for falling because I receive a daily scheduled antidepressant med [medication], I have confusion, Hx [history] of wandering & [and] a hx of crawling on the floor when attempting to get up. . . . Approach: . . . May use EZ [a sit to stand mechanical lift] stand prn [as needed] . . ." The CNA care guide (a smaller version of the care plan) stated, "Assist with all cares, W/C for Mob. [mobility].Repo [reposition] Schedule, . . . low bed."

Observation on 07/19/16 at 10:57 a.m. showed two CNAs (#11 and #12) applied a gaitbelt loosely around Resident #5's waist and

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transferred her from a recliner to a wheelchair. The CNA (#12) assisted the resident by lifting with the gaitbelt and under the resident's right arm. The CNAs then transported Resident #5 to her room to use the bathroom. Both CNAs utilized the loose gaitbelt to assist the resident to stand and observation showed the gaitbelt slid up to the residents armpits. When Resident #5 had finished on the toilet, both CNAs (#11 and #12) assisted her to stand by lifting up under her armpits and not utilizing the gaitbelt. Resident #5 began to lower herself to the floor so the CNAs placed her back on the toilet. The CNA (#11) stated when Resident #5 is weak, the CNAs ask a nurse if they can use the EZ stand. Again, the CNAs assisted the resident to stand by lifting under her armpits and not utilizing the gaitbelt. Resident #5 stated, "Ouch, my arms, my arms!" The CNA (#11) stated, "I probably should have used the lift . . ."

Observation on 07/19/16 at 12:05 p.m. showed two CNAs (#11 and #12) applied a gaitbelt around Resident #5's waist and assisted her from a wheelchair to bed. The CNA (#12) failed to utilized the gaitbelt and lifted under the resident's armpit.

Observation on 07/19/16 at 2:25 p.m. showed Resident #5 seated on the edge of the bed with a gaitbelt around her waist and two CNAs (#11 and #12) next to her. A nurse (#13) entered the room and stated she needed to assess how Resident #5 walks and transfers because the CNAs had requested to use the EZ stand. The CNAs utilized the gaitbelt and assisted the resident to stand while the nurse (#13) placed a four-wheeled walker in front of her. Resident #5

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walked approximately six feet and began to lower herself to the floor. The nurse (#) stated, "She's walking okay." The CNA (#12) held onto the gait belt while the other CNA (#11) held onto the waistband of the resident's pants. When they reached the bathroom, the CNAs asked Resident #5 to turn and sit on the toilet but the resident could not do so. The CNA (#12) placed her knee under the resident's buttocks and the other CNA (#11) held the resident's waistband and they eventually assisted her onto the toilet. When Resident #5 had finished on the toilet, the CNA (#11) held onto the gaitbelt, the other CNA (#12) lifted under the resident's left armpit, and they both transferred her back to the wheelchair.

- Review of Resident #2's medical record occurred on July 18-20, 2016 and diagnoses included dementia. The significant change MDS, dated 05/19/16, identified the resident required extensive assistance of two or more staff members for transfers and locomotion.

The current care plan stated, "Problem, I am at risk for falling because I have balance problems during transitioning and ambulation . . . Approach . . . Assist of 2 with all transfers and ambulation . . ."

Observation on 07/19/16 at 12:30 p.m. showed two CNAs (#11 and #12) applied a gaitbelt loosely around Resident #2's waist and assisted him to walk to the bathroom. The CNAs (#11 and #12) assisted the resident to stand from the toilet by grasping the loose gaitbelt with one hand and lifting under the resident's arms with their other hand.

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F 323	Continued From page 15 Observation on 07/19/16 at 4:40 p.m. showed two CNAs (#8 and #9) applied a gaitbelt around Resident #2's waist and assisted him to the bathroom. When assisting the resident to stand from the recliner and his wheelchair, both CNAs (#8 and #9) grasped the gaitbelt with one hand and lifted under the resident's armpit with their other hand. During an interview on 07/20/16 at 4:45 p.m., an administrative nurse (#1) stated she expected staff to utilize a gait belt appropriately when transferring residents and avoid lifting on the residents' arms.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide fluids to maintain adequate hydration for 5 of 5 sampled residents (Resident #2, #3, #4, #5, and #8) who required staff assistance with food/fluid intake. Failure to consistently offer fluids to residents who are unable to access them independently placed them at risk for dehydration, urinary tract infections (UTIs), and constipation. Findings include:	F 327	1)Corrective action of residents #2, #3, #4, #5, and #8 will be accomplished by staff education on providing hydration with cares. 2)All residents have the potential to be affected. 3)Nurses and CNA education on hydration and offering fluids with cares will be provided on 8/17/16 at a mandatory nurses meeting. 4)QA of staff providing hydration with cares will be completed prior to completion date, weekly X4, monthly X2, and quarterly X3. QA will be completed by nursing staff and reviewed by the QA	8/25/16

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F 327	Continued From page 16 Review of the facility policy titled "Nutrition - Hydration" occurred on 07/21/16. This policy, revised February 2009, stated, ". . . Fluids will be available and offered at the bedside, with medication administration and with meals. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and constipation. The current Minimum Data Set (MDS), dated 05/23/16, identified extensive assistance from one person for eating. Resident #3's current care plan identified, ". . . I have the potential to become dehydrated because I may not always drink all of the fluids provided to me. . . . I do not consume adequate liquids. Offer liquids while I am awake. I do not ask for liquids as needed. I do not always realize I am thirsty. . . . I have the potential to be constipated because I have a hx [history] of constipation. . . . Provide and encourage me to drink fluids in between meals, with cares, and when I'm awake at night. . . ." Observation of personal cares occurred with Resident #3 on 07/18/16 at 4:06 p.m., 07/19/16 at 1:55 p.m., and 07/19/16 at 4:02 p.m. Observation showed no fluids available in Resident #3's room, and staff failed to offer/encourage fluids during these observations. - Review of Resident #2's medical record occurred on July 18-20, 2016 and diagnoses included constipation, dementia, and history of gastrointestinal bleeding. The significant change MDS, dated 05/19/16, identified the resident required extensive assistance for eating. Review of the current care plan stated, "Problem	F 327	coordinator.	

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F 327	Continued From page 17 . . . [Resident #2] has a potential to become dehydrated because he takes a diuretic everyday, has Hx [history] of GI [gastrointestinal bleed] and because of his dementia . . . Problem . . . has a potential of becoming constipated because he has a h/o [history of] constipation and he receives a diuretic daily . . . Approach . . . Provide and encourage fluids in between meals, with cares, and when awake at night . . ." Observation on 07/19/16 at 4:40 p.m. identified two CNAs (#8 and #9) assisted Resident #2 with toileting, transferred him into his wheelchair, and transported him to the lounge area. Observation showed a water pitcher sitting on top of his dresser in his room, inaccessible by the resident, and an empty glass upside down on top of the pitcher. The staff members failed to offer Resident #2 fluids. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, diabetes mellitus and edema. Medications to aid in reducing the edema included furosemide 40 milligrams (mg) one tablet daily. The current care plan stated, ". . . I have the potential to become dehydrated because I have a daily scheduled diuretic med . . . Offer and encourage me fluids PRN [as needed]." Observation of cares occurred on 07/19/16 at 9:23 a.m., 9:57 a.m., 10:56 a.m., 11:15 a.m., and 4:51 p.m.; and on 07/20/16 at 2:18 p.m. and 3:54 p.m. All observations showed facility staff failed to offer/assist Resident #4 with fluids. - Review of Resident #8's medical record	F 327		

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occurred on July 20-21, 2016. Diagnosis included dementia. The current care plan stated, "I have the potential to be constipated because I may not move around as much as I used to and I receive daily schedule Opiate Narcotics . . . Provide and encourage me to drink fluids in between meals, with cares, and when I'm awake at night."

Observation of cares occurred on 07/20/16 at 10:58 a.m., 2:31 p. m., 3:15 p.m, 3:42 p.m., and 3:46 p.m. and showed facility staff failed to offer/assist Resident #8 with fluids.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, constipation, and recurrent UTIs. The quarterly MDS, dated 06/29/16, identified severe cognitive impairment and extensive assistance from one person for eating.

Resident #5's current care plan stated, "Problem: I have the potential to be constipated because I may not always drink all of my fluids provided . . . Provide and encourage me to drink fluids . . ."

Observation on 07/19/16 at 12:05 p.m. showed two CNAs (#11 and #12) assisted Resident #5 to the bathroom and then to bed. Observation showed a glass of water on the night stand next to the bed. The CNAs failed to offer the resident water before or after cares.

Observation on 07/20/46 at 11:00 a.m. showed two CNAs (6# and #11) assisted Resident #5 to the bathroom, provided personal cares, and then assisted her back in to the wheelchair. The CNA (#6) asked the resident if she was thirsty, if she

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F 327	Continued From page 19 wanted to go to exercise, and if she wanted to go to music. Resident #5 stated "No" to each question. The CNA (#11) held a glass of water to the resident's lips, the resident shook her head no but accepted the water. During an interview on the afternoon of 07/20/16, an administrative nurse (#1) stated she expected staff to offer fluids with cares.	F 327		
F 441 SS=E	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	F 441		8/25/16

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F 441	Continued From page 20 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure proper maintenance of 1 of 1 water/ice dispenser used for residents. Failure to ensure proper maintenance occurred on a regular basis, such as sanitizing and de-mineralizing to prevent the development of mold and the production of corrosion, has the potential to affect the health of residents consuming the water/ice from the dispenser. Findings include: Review of manufacturer's instructions for the water/ice dispenser occurred on 07/20/16. The instructions, dated November 2008, stated, ". . . Maintenance and Cleaning/Sanitizing should be scheduled at a minimum of twice per year . . ." Observation of the environment occurred on 07/20/16 at 3:00 p.m. with a maintenance staff member (#10) and identified a water/ice dispenser used for residents in the dining room. During an interview on the afternoon of 07/20/16,	F 441	1)Corrective action was accomplished by cleaning and sanitizing of the ice machine on 7/25/16. 2)All residents have potential to be affected. 3)Midwest Refrigeration cleaned and sanitized the ice machine on 7/25/16. Bi-annual cleaning will be contracted with the same company. 4)The maintenance director will provide proof of bi-annual contract and cleaning record to the QA coordinator prior to completion date. QA Coordinator will monitor for biannual cleaning Q 6 months.	

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F 441	Continued From page 21 the maintenance staff member (#10) stated the facility contracted with an outside company to clean and disinfect the water/ice dispenser yearly.	F 441		