STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	12/21/2017

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 12/18/17 and completed on 12/21/17, the sample included 12 residents for complete review and no closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		1/26/18

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

Electronically Signed | 01/19/2018

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F 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 2 of 14 sampled residents (Resident #3 and #13). Failure to revise the care plan to reflect Resident 13's wanderguard and current laxatives and Resident #3's infection process/precautions limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility's policy titled "Care Plan" occurred on 12/21/17. This undated policy stated, ". . . 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas . . . e. Reflect treatment goals, timetables, and objectives in measurable outcomes . . . 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. . . ." Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dementia and constipation. The current care plan stated, ". . . Constipation . . . Fleets saline enema per orders . . . MOM [Milk of Magnesia] per orders." Review of the resident's December 2017 electronic medication administration record (eMAR) identified Bisacodyl suppository 10 milligrams (mg) every 72 hours as needed (PRN). The care plan failed to reflect the current	F 657	Failure to care plan wander guard: 1. Resident #13 is identified as needing a wander guard as reflective in the Elopement Risk Assessment done 1/11/2018. Care plan revised to reflect a measureable goal/interventions/tasks; done 1/12/2018. 2. Six other residents with a wander guard had an Elopement Risk Assessment done by 1/11/2018. Each resident with a wander guard; their care plans were revised to reflect their behavior with a measureable goal/intervention/tasks. Completed by 1/12/2018. 3. All residents will be assessed on admit with an Elopement Risk Assessment. Those residents found at risk and a wander guard placed, will have an individualized care plan reflecting their behavior with measurable goals/interventions/tasks. IDT will review the residents with wander guards quarterly for appropriateness. Nursing Staff will be educated on need of notification of wander guard placement to DON and/or SS. Nursing Staff will be educated on the need of documentation of wandering patterns and wandering interventions. 4. Social Service and/or designee complete QA of Elopement Risk Assessments on every admit and/or new	

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F 657	Continued From page 2 protocol/orders for PRN laxatives. Observation on 12/18/17 at 2:35 p.m., showed a code alert (wanderguard) on Resident #13's wheelchair. An unidentified staff member stated the resident had, in the past, tried to get outside in his wheelchair through one of the facility's doors and at times still wanders. Review of Resident #13's progress notes for the last six months showed no wandering/elopement behaviors. The current care plan stated, ". . . Interventions/Tasks . . . CODE ALERT: check this daily. . . ." Resident #13's care plan failed to identify a problem related to wandering/elopement behavior, a measurable goal, and interventions/tasks other than checking the code alert daily. During an interview on 12/21/17 at 9:45 a.m., an administrative staff member (#1) agreed the care plan lacked the resident's current laxative and behavior of wandering. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included multiple sclerosis, and history of methicillin resistant staphlococcus infection (MRSA). The current care planned stated, ". . . has a history of UTI's (urinary tract infection) and MRSA. . . . Intervention: has a strong Hx (history) of MRSA in urine. . . . has a tendency to develop Pneumonia and MRSA. 3/23/17 (Resident name) has MRSA in his sputum . . ."	F 657	placement of wander guard, notification to SS and/or DON, care plan regarding wander guards and documentation of wander guards weekly x4, monthly x2, then quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 1/26/18. Failure to care plan infection process/precautions: 1. Resident #3 care plan was revised to reflect the use of PPE, individualized for this resident. The care plan was revised as follows: Res #3 has a history of MDRO's. Infection prevention protocol will be followed for each identified active infection. When no active infection present, PPE can be available for staff to use beyond the policy for sense of protection and/or Resident #3. 2. Resident #4 was found to also have a history of frequent MDRO's. This resident's care plan was revised as follows: Infection prevention protocol will be followed for each identified active infection. When no active infection present, PPE can be available for staff to use beyond the policy for sense of protection and/or Resident. 3. The policy "Multidrug-Resistant Organisms (MDROs)" policy will be revised to reflect the use of PPE, as it pertains to frequent infliction of MDRO's.	

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F 657	Continued From page 3 Observation on 12/18/17 at 10:20 a.m. showed personnel protection equipment (PPE) hanging on the outside of Resident #3's door. During an interview on 12/18/17, at approximately 10:30 a.m., an administrative nurse (#4) stated Resident #3 has history of MRSA in his sputum, and staff wear a mask when going into his room. Observation on 12/1817 at 11:02 a.m. identified Resident #3 in bed, with a congested non-productive cough. During an interview on the afternoon of 12/18/17, an administrative nurse (#1) explained Resident #3 has a history of colonized MRSA, but housekeepers feel the need to wear a mask when in the room. Observation on 12/19/17 showed a CNA (#6) donned gloves and a mask to empty the foley catheter bag for Resident #3. The CNA (#5) explained she only uses a mask when emptying the foley catheter bag. During an interview on the afternoon of 12/20/17 an administrative nurse (#4) stated staff will wear a mask to protect Resident #3. She further stated she would expect staff to wear a mask when within three feet of the resident, if the resident is coughing. Resident #3's care plan failed to identify when staff needed PPE while caring for and when entering the resident's room. During an interview on 12/21/17 at 10:12 a.m. an	F 657	All residents who have been determined to have frequent MDRO's will be reviewed for use of PPE and the care plan will be individualized and reflect according to the policy. Staff educated on the MDRO policy revision and reflection of care plan on January 24 and repeated January 25. 4. Infection Prevention and MDS coordinator will evaluate new and current residents for MDRO's , and care plan addresses the use of PPE, which is individualized for each resident according to policy, weekly x4, monthly x2, then quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 1/26/2018. Failure to reflect the current protocol/orders for PRN laxatives: 1. Resident #13 bowel pattern reviewed with nursing staff and the medical provider. Order received to adjust Senna S one tab po daily. Care plan revised to reflect the order change. 2. Thirteen residents bowel patterns were reviewed by nursing staff and the medical provider. Care plans revised to reflect the order changes. 3. All new residents will have an admission assessment which includes	

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F 657	Continued From page 4 administrative nurse (#1) stated she would expect Resident #3's care plan to identify what PPE is needed when caring for the resident.	F 657	bowel status. Need for laxatives will be addressed for the bowel status with input from the resident, if possible, past history and with the medical provider. 4. Director of Nursing and/or designee will evaluate care plans to ensure the care plan/s reflect the current orders for laxatives weekly x4, monthly x2, then quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 1/26/2018.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional standards, resident interview, and staff interview, the facility failed to ensure standards of practice were followed for 6 of 11 sampled residents (Resident #3, #4, #10, #12, #13, and #33) and one supplemental resident (Resident #34) who received scheduled or as needed (PRN) laxatives. Failure to establish guidelines for consistent administration of scheduled laxatives, with dosage ranges of 1-3 tablets, and PRN laxatives may not meet the specific needs or least invasive intervention for residents. Findings include:	F 658	1. Residents #3, #4, #10, #12, #13, #33. #34 assessed for personal bowel status. Laxatives were reviewed by medical provider/s according to their bowel status and orders adjusted accordingly. 2. Thirteen other residents were assessed for personal bowel status. Laxatives were reviewed by medical provider/s according to their bowel status and orders adjusted accordingly. 3. A Bowel Management Guideline for Constipation will be written for consistency of laxative administration,	1/26/18

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F 658	Continued From page 5 Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 1225, stated, ". . . Continual use of laxatives to encourage bowel evacuation weakens the bowel's natural responses to fecal distention, resulting in chronic constipation. . . . Types of Laxatives . . . magnesium salts [Milk of Magnesia] . . . Use caution when giving to older adults. . . . Bisacodyl . . . senna . . . Use only for short periods of time. Prolonged use may cause fluid and electrolyte imbalance. . . ." - Observation of medication pass on 12/19/17 at 8:25 a.m. showed a medication nurse (#3) gave Resident #34 one tablet of Senna. The eMAR identified "Senna 8.6 mg 1-3 tablets daily." The medication nurse stated the resident had a BM yesterday and needed only one tablet today. The medication nurse verified the facility had no written guideline to determine whether to administer 1, 2, or 3 tablets. During an interview on 12/21/17 at 9:45 a.m., an administrative nurse (#1) verified the facility had no policy/guideline on bowel protocol for nursing staff to follow and/or use the least invasive laxative intervention. - Review of Resident #4's medical record occurred on all days of survey. The care plan, dated 07/14/12, stated, "CONSTIPATION: [Name of Resident #4] has constipation. . . . will have a BM every 2-3 days. . . . Bisacodyl suppository per orders [initiated 06/08/2014] . . . MOM per orders [initiated 10/12/2013] . . . Senekot [sic] as ordered [initiated 10/09/2017] . . ."	F 658	dosage ranges, and PRN laxatives to meet specific needs and least invasive intervention for residents. Educate nursing staff on the Bowel Management Guideline for Constipation and documentation of bowel status changes. CNA□s/nurses educated on consistent and accurate charting of bowel movements and characteristics. Nursing education meeting scheduled for January 24 and repeated January 25. 4. Director of Nursing and/or designee will monitor nursing adherence to the Bowel Management Guidelines for constipation weekly x4, monthly x2, then quarterly x3. All reports will be submitted to QA Committee quarterly x4 quarters. 5. 1.26.2018	

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F 658	Continued From page 6 Resident #4's medication orders included Senokot S 8.6-50 mg two tablets scheduled daily for "constipation," bisacodyl suppository 10 mg rectally every 72 hours PRN for "stool softener," and MOM with instructions to "Give 1 dose by mouth as needed for constipation. 1 dose = 15-30 mL [milliliters]. Adjust as needed for diarrhea." The eMAR for December 1-20 showed staff administered a bisacodyl suppository five times and offered MOM 30 mL twice, with the resident refusing it once. The facility failed to offer MOM by mouth on three occasions before administering the rectal suppository. The bowel record identified Resident #4 had a BM every one to three days from December 1-19. During an interview on 12/19/17 at 10:04 a.m., Resident #4 stated, "They want me to have a BM too often." The resident indicated she did not like receiving suppositories. The facility failed to establish a bowel protocol policy/guideline for laxative use to ensure nursing staff followed consistent and appropriate laxative guidelines for residents experiencing constipation. - Review of Resident #33's medical record occurred on all days of survey. The care plan, dated 07/28/17, stated, "[Name of Resident #33] will have a bowel movement at least every 3rd day. . . . Prune juice: offer this as needed. RX [prescription]: Miralax po [orally] as ordered [initiated 08/24/17], RX: Senna S po as ordered [initiated 08/04/17] . . ." Resident #33's medication orders included	F 658		

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F 658	Continued From page 7	F 658		

MiraLax powder 17 grams daily for "constipation" and Senna-S 8.6-50 mg "Give 1 tablet by mouth one time a day for constipation give 1-3 tabs [tablets] adjust as needed." The eMAR for December 1-20 showed staff administered two tablets of Senna-S on 18 days, one tablet on one day, and three tablets on one day. The bowel record identified Resident #33 had one or more BMs daily from December 1-19, except on one occasion.

During an interview on the morning of 12/20/17, a nurse (#2) stated when administering the scheduled Senna-S of one to three tablets for Resident #33, the nurse looked back on the eMAR and administered the number of tablets the previous nurse administered.

The facility failed to establish a bowel protocol policy/guideline for the staff to determine whether to administer one or more tablets of Senna-S to Resident #33.

- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included constipation. The current care plan stated, "BOWEL FUNCTION/CONSTIPATION . . . Goal: . . . bowels will move at least every 3 days without a consistent need of laxatives . . . Interventions: . . . PRUNE JUICE: offer this prior to laxatives if needed . . . Miralax po as ordered, Senna-S po as ordered, STANDING ORDERS: of laxatives such as MOM po, Bisacodyl supp [suppository] or fleets enema . . ."

Review of Resident #10's December 2017 eMAR showed two PRN laxatives. The PRN order stated, "Milk of Magnesia Suspension 1200

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F 658	Continued From page 8 MG/15ML Give 1 dose by mouth as needed for constipation. 1 dose = 15-30mL." Nursing staff administered a dose of 15 ml of MOM on 12/02/17 and 12/06/17. Documentation on the PRN MAR stated MOM ineffective though the resident had a BM on December 2, 3, 4, 7, and 8. The record lacked directions regarding the use laxatives including when to administer 15 ml or 30 ml of MOM. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included constipation. The current care plan stated, " . . . Constipation: Goal: . . . will have stool every 2-3 days. . . " Review of Resident #3's December 2017 eMAR showed Miralax 17 grams one time daily, Senna -S 8.6-50 mg give one dose two times a day for constipation. May give liquid Senna or crush tablets. If giving liquid give 5 milliliters; if giving tablets 1 dose = 1-2 tabs adjust as needed. The MAR identified Resident #3 received Senna-S one or two tabs with no consistency as related to the resident's BMs. The facility failed to establish a bowel protocol policy/guideline for the staff to determine whether to administer one or two tablets of Senna-S to Resident #3. - Review of Resident #12's medical record occurred on all days of survey. The resident did not have a diagnosis or care plan for constipation. Resident #12's December MAR identified	F 658		

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F 658	Continued From page 9 Senna-S 8.6-50 mg one - two tablets daily. The MAR identified two tablets given every day except one tablet on December 5, 6, and 8. Review of the December BM records identified the resident with loose diarrhea on December 2, 3, 7, 8, 9, 10, 11, 14, and 16. The resident continued to receive two Senna -S even when having loose diarrhea stools. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dementia and constipation. The current care plan stated, ". . . will have a soft formed BM [bowel movement] every 2-3 days." Review of Resident #13's December 2017 electronic medication administration record (eMAR) showed one PRN laxative. On 12/13/17 at 1:11 p.m. nursing staff administered the PRN Bisacodyl suppository 10 milligrams (ordered every 72 hours for constipation). Review of the bowel record showed staff administered the suppository on the third day of no BM. The record failed to identify other interventions used prior to the third day of no BM. Failure to establish a bowel protocol policy/guideline for consistent administration of laxatives may not meet the specific needs of residents experiencing constipation.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		1/26/18

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F 692	Continued From page 10 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #12) identified with weight loss. Failure to ensure an accurate record/assessment of Resident #12's weight may have caused a delay in implementing nutrition and hydration measures. Findings included: Review of Resident #12's medical record occurred on all days of survey. Diagnoses included dementia and depression. Physician orders stated assess weight weekly and as ordered. The current care plan stated, " . . . [Resident name] is at moderate nutrition risk due to dx [diagnosis] of dementia and depression and has a hx [history] of weight loss. Currently her wt [weight] has remained stable (current weight is 147.8#) . . . Interventions . . . weight weekly or	F 692	1. Resident #12 was weighed on 11/14/18. Resident care plan revised to daily weights when awake due to multiple sleepy days, which resident refuses weights. 2. One other resident was found to not have a recent weight pattern. Weight was done 1/9/18 and no weight loss was found. 3. CNA training/competency will be completed for accurate and timely weights per policy or per physician order. IDT will review resident weights bi-monthly and address any missing weights or significant weight loss. Significant weight losses will be referred to dietician and/or medical provider. Nursing education meeting planned for	

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F 692	Continued From page 11 per physician's order. Review of Resident #12's weight record showed the following: 08/14/17 - 151.2 pounds (lbs) 08/20/17 - 149.4 lbs 09/06/17 - 149.3 lbs 09/13/17 - 149.8 lbs 09/26/17 - 148.2 lbs 10/04/17 - 147.8 lbs The record lacked weights between 10/04/17 to 12/18/17 During an interview on 12/18/17 at 3:22 p.m., an administrative nurse (#1) confirmed staff failed to weigh Resident #12 weekly and did not obtain a weight from 10/04/17 to 12/18/17. On 12/19/17 staff recorded Resident #12's weight as 138 lbs, a loss of 9.8 lbs and a 6.7% weight loss in 11 weeks.	F 692	January 24 and repeated January 25 related to timely and accurate weights and significant weight loss. 4. Director of Nursing and/or QA manager will monitor timeliness of resident weight results per policy or as physician ordered weekly x4, monthly x2, and then quarterly x3. Director of Nursing and/or QA manager will submit QA findings to QA Committee quarterly x4. 5. 1/26/18	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an effective pest control barrier for 1 of 1 kitchen with an opening to the outside on an exterior door. Failure to maintain the integrity of the door has the potential to allow the entrance of mice, snakes, and other pests along with the dirt, gravel, and rusty metal flakes.	F 925	1. A tailored metal plate was placed over the existing door frame to secure from the outside and avoid entrances by pests. Metal plate was placed 1/9/2018. 2. All other entrances checked for variances and none identified.	1/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 925	Continued From page 12 Finding include An tour of the kitchen occurred on 12/21/17 at 8:40 a.m., with a dietary staff member (#6). Observation showed a door with access to the outside near the walk-in cooler, walk-in freezer, and an open rack for bread storage. Damage to the door frame caused a visible gap between the door and door frame at the bottom of the door. Observation showed dirt blown in from outside, rusty metal flakes, and chips of cement on the floor. During an interview on 12/21/17 at 9:30 a.m., maintenance staff members (#7 and #8) identified the pest control company comes quarterly, supplies live traps, and will come more frequently if requested. An observation of the outside of the kitchen door occurred during the interview and observation failed to show a live trap near the visible gap in the kitchen door. The maintenance staff (#7 and #8) identified they knew of the gap, but have been unable to repair the damage.	F 925	3. Complete door frame will be replaced when the weather is advantageous. Project to be completed by June 15, 2018 or sooner, dependent on weather. Environmental Services (EVS) □ maintenance was educated on observing and reporting any door assembly variances on 1/9/2018. 4. EVS will check all LTC exit doors quarterly x4 for any door assembly variances. Maintenance will inform administration as soon as possible and complete repairs as needed. All reports will be submitted to QA Committee quarterly x4 quarters. 5. Date: see above.	