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	355108	A. BUILDING _____ B. WING _____	12/20/2017

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 12/18/17 and completed on 12/20/17, the sample included 13 residents for review and 3 closed records for review. The sample included 2 additional residents for specific concerns during the survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		1/26/18

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

Electronically Signed | 01/15/2018

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F 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident's physician for 1 of 4 sampled residents (Resident #40) with a blood sugar below the ordered parameter readings. Failure to notify the physician of blood sugar results out of ordered parameters may result in complications to the resident and prevented the physician from evaluating a treatment plan. Findings include: Review of Resident #40's medical record occurred on all days of survey. Diagnoses included, type 2 diabetes. Medications included, "Glipizide [antidiabetic] 20 mg[milligrams] by mouth two times a day, Metforman [antidiabetic]	F 580	1. The physician reviewed Resident #40's blood sugars on rounds that occurred on 12/5/17 and no changes were made to the resident's orders to manage blood sugars. 2. Any resident with Diabetes with blood sugar parameters can be affected by this practice. 3. a. Information was provided in the shift-to-shift report on 12-24-17 for nurses and Medication Aides regarding expectations to contact the provider if blood sugars are outside the parameters for residents at the time the blood sugar is taken. b. Education will be provided to nurses and med aides on January 22nd on blood	

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F 580	Continued From page 2 1000 mg by mouth two times a day, Levemir [antidiabetic] inject 70 units subcutaneously at bedtime." A physician's order dated, 03/20/17, stated "accucheck BID [twice a day] every Monday and Friday. BS [blood sugar] < [less than] 70 or >[greater than] 350, call physician." Review of the November Medication Administration Record (MAR), on 12/20/17, showed a blood sugar reading of "60" on 11/13/17 at 8:00 a.m. Review of the medical record showed the facility failed to notify Resident #40's physician of the blood sugar reading. During an interview on 12/20/17, at 10:50 a.m. an administrative nurse (#1) stated she would expect the nurse to call the physician of a blood sugar reading outside of ordered parameters.	F 580	sugar parameters and physician notification. 4. QA will be conducted by the Nursing Services Coordinator or her designee weekly for one month, monthly for two months and quarterly thereafter for the remainder of the year to ensure the provider is notified of blood sugars falling outside the range identified.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		1/26/18

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F 582	Continued From page 3 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility	F 582	1. N/A 2. All residents being discharged from	

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F 582	Continued From page 4 failed to provide the CMS 10123-NOMNC (Notice of Medicare Noncoverage) forms to 3 of 3 residents (Resident #15, #16, and #33) discharged in the last 6 months from Medicare Part A, with benefit days remaining. Failure of the facility to provide the required Medicare noncoverage notices limited the residents' ability to exercise their rights in regard to Medicare Part A services. Findings include: On the afternoon of 12/19/17, review of the Medicare Part A letters/notices for Resident #15, #16, and #33 showed the facility failed to provide the CMS 10123-NOMNC to these residents before Medicare Part A coverage and/or services ended. The facility failed to provide the CMS 10123-NOMNC to the following residents prior to their last covered day of Medicare Part A services: * Resident #15 - last covered day July 13, 2017 * Resident #16 - last covered day May 31, 2017 * Resident #33 - last covered day June 14, 2017 During an interview on 12/19/17 at 4:00 p.m., an administrative staff member (#6) verified the facility did not provide the CMS 10123-NOMNC to these residents.	F 582	Medicare services have the potential to be affected. 3. Form 10123-NOMNC will be given to all residents or their representatives when a discharge from Medicare is planned. The Nursing Services Coordinator and MDS Coordinator who carry out this notification have been educated that the "Notice of Medicare Non-Coverage" form must be completed in addition to the denial letter. A Medicare education binder is being developed and Form 10123-NOMNC will be added to that binder. 4. QA will be conducted monthly for three months and quarterly thereafter for the remainder of the year. The Business Office Coordinator or her designee will carry out this QA.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		1/26/18

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F 623	Continued From page 5 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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F 623	Continued From page 6 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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F 623	Continued From page 7 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident and/or family member, and Office of the State Long-term Care Ombudsman, in writing, of a transfer outside of the facility, including the destination and the reason for the transfer, and the resident's right to appeal the action for 1 of 3 sampled residents (Resident #32) transferred to the hospital. Failure to provide a notice of transfer does not allow the resident or guardian the right to make an informed choice regarding the resident's rights. Findings include: Review of Resident #32's medical record occurred on all days of survey. The progress notes identified the facility transferred the resident to the hospital on 08/07/17. The record lacked evidence the facility provided the resident and/or the resident's family member/legal guardian a written notice of transfer.	F 623	1. Resident #32 returned to the same room in the facility immediately following his hospitalization. Resident #32 and his family were aware of his transfer to the hospital and were in agreement with it at the time it occurred. 2. All residents being transferred or discharged from the facility have the potential to be affected by this practice. 3. Education will be provided at the nurse meeting on January 22nd to review the requirements related to the completion of these forms at the time of a transfer or discharge. 4. QA will be completed by the Business Office Coordinator or her designee monthly for three months and quarterly thereafter for the remainder of the year to ensure all forms have been completed.	

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F 623	Continued From page 8 During an interview on 12/20/17 at 3:04 p.m., an administrative nurse (#1) stated they were unable to locate a transfer notice for the resident's hospitalization on 08/07/17.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 3 sampled residents (Resident #23 and #30) who received scheduled opioids (a pain medication). Failure to accurately code opioids does not allow the residents' assessments to reflect their current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and the care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2017, page N-7 stated, ". . . N0410H, Opioid: Record the number of days an opioid medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) . . ." - Review of Resident #30's medical record occurred on December 18-20, 2017. Resident	F 641	1. A corrected MDS was completed and submitted for residents #23 and #30. 2. All residents on opiod medications have the potential to be affected by this practice. 3. The facility contracted pharmacist will provide education for the MDS nurse regarding the opiod classification of pain medication. 4. QA will be completed by the Nursing Services Coordinator monthly for three months and quarterly thereafter for the remainder of the year on the correct coding of N0410H.	1/26/18

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F 641	Continued From page 9 #30's Medication Administration Record (MAR) identified this resident received an opioid medication, Hydrocodone-Acetaminophen 5-325 milligrams (mg), twice daily in October and November of 2017. Review of Resident #30's current annual MDS, dated 11/04/17, failed to show this resident received opioid medication during the 7-day look-back period. During an interview on the morning of 12/20/17, an administrative nurse (#7) verified she failed to accurately code item N0410H, Opioid, on Resident #30's 11/04/17 MDS. - Review of Resident #23's medical record occurred on December 18-20, 2017. The resident's September and October 2017 MARs showed he received Tramadol (an opioid medication) 50 mg twice a day during those months. Resident #23's quarterly MDS, dated 10/19/17, failed to identify the resident received an opioid medication during 7-day look-back period. During an interview on 12/19/17 at 4:37 p.m. an administrative nurse (#7) confirmed she did not accurately code item N0410H, Opioid, for Resident #23's 10/19/17 MDS.	F 641		
F 642 SS=C	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and	F 642		1/25/18

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F 642	Continued From page 10 certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) 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) 3.0 User's Manual (Version 1.15), and staff interview, facility staff failed to accurately sign and certify (date) Section F, items F0400 and F0500, of the Minimum Data Set (MDS) for 12 of 12 sampled residents (Resident #5, #12, #15, #21, #23, #29, #30, #32, #36, #38, #39, and #40) interviewed regarding their daily and activity preferences. Failure to maintain accurately documented medical records, including MDSs, does not provide continuity of care and/or accurate communication to the staff members involved in providing the care to the residents.	F 642	1. Immediately after the survey was completed, staff members completing section F were instructed to keep their paper documentation of the interview, date and sign it, and put it in the chart to show the date of the interview was completed in the 7 day look back period. 2. All residents have the potential to be affected by this practice. 3. A meeting was held with the staff completing Section F on 1/10/18. Also in attendance was the MDS Coordinator. Section F was reviewed, along with the ARD date and 7-day look back period. The staff completing section F will now complete the interview directly into the	

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F 642	Continued From page 11 Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2017, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations and events through the end of the day (midnight) of the ARD . . ." Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified in the RAI User's Manual on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. The Centers for Medicare and Medicaid Services (CMS) identified the resident interviews for Cognition (Section C), Preferences (Section F), and Participation in Assessment and Goal Setting (Section Q) can be done any time during the 7-day look-back period; and for these interview items a staff member should sign and date Z0400 on the actual date of the resident interview.	F 642	MDS on the date the interview occurs during the 7-day look back period. They will use the calendar put out for nursing that shows the ARD date and 7-day look back period as a guide for when the interviews will occur. 4. QA will be completed by the Resident Care Coordinator (or her designee) monthly for the first three months and quarterly thereafter for a year to monitor the dates of completion of Section F to ensure they are signed and dated on the actual date of the resident interview.	

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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 642	Continued From page 12 - Review of Resident #5's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 03/14/17, identified a facility staff member completed the resident interview items for Section F on 03/15/17 (one day after the ARD, rather than during the 7-day look-back period). - Review of Resident #12's medical record occurred December 18-20, 2017. A significant change in status MDS, with an ARD of 09/30/17, identified a facility staff member completed the resident interview items for Section F on 10/07/17 (seven days after the ARD, rather than during the 7-day look-back period). - Review of Resident #15's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 07/07/17, identified a facility staff member completed the resident interview items for Section F on 07/13/17 (six days after the ARD, rather than during the 7-day look-back period). - Review of Resident #21's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 04/15/17, identified a facility staff member completed the resident interview items for Section F on 04/22/17 (seven days after the ARD, rather than during the 7-day look-back period). - Review of Resident #23's medical record occurred December 18-20, 2017. An admission MDS, with an ARD of 01/26/17, identified a facility staff member completed the resident interview items for Section F on 02/01/17 (six days after the ARD, rather than during the 7-day	F 642		

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F 642	Continued From page 13 look-back period). - Review of Resident #29's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 02/05/17, identified a facility staff member completed the resident interview items for Section F on 02/10/17 (five days after the ARD, rather than during the 7-day look-back period). - Review of Resident #30's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 11/04/17, identified a facility staff member completed the resident interview items for Section F on 11/11/17 (seven days after the ARD, rather than during the 7-day look-back period). - Review of Resident #32's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 08/18/17, identified a facility staff member completed the resident interview items for Section F on 08/27/17 (nine days after the ARD, rather than during the 7-day look-back period). - Review of Resident #36's medical record occurred December 18-20, 2017. An admission MDS, with an ARD of 05/19/17, identified a facility staff member completed the resident interview items for Section F on 05/26/17 (seven days after the ARD, rather than during the 7-day look-back period). - Review of Resident #38's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 11/17/17, identified a facility staff member completed the resident interview	F 642		

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F 642	Continued From page 14 items for Section F on 11/20/17 (three days after the ARD, rather than during the 7-day look-back period). - Review of Resident #39's medical record occurred December 18-20, 2017. An annual MDS, with an ARD of 02/18/17, identified a facility staff member completed the resident interview items for Section F on 02/22/17 (four days after the ARD, rather than during the 7-day look-back period). - Review of Resident #40's medical record occurred December 18-20, 2017. An admission MDS, with an ARD of 03/06/17, identified a facility staff member completed the resident interview items for Section F on 03/12/17 (six days after the ARD, rather than during the 7-day look-back period). During an interview on the afternoon of 12/20/17, three facility staff members (#7, #8, and #9) identified staff had completed the above-stated resident interviews for items F0400 and F0500 during the 7-day look-back period, but failed to sign and date Z0400 on the actual date of the resident interview, as required.	F 642		
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.	F 657		1/26/18

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F 657	Continued From page 15 (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. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 11/23/16 Based on observation, record review, and resident and staff interview, the facility failed to review and revise the current care plan for 1 of 3 sampled resident (Resident #5) with behaviors impacting other residents (Resident #23 and 29). Failure to develop interventions for staff to implement when Resident #5 displayed hollering behaviors resulted in other residents expressing concerns regarding Resident #5 making loud disruptive noises at night. Findings include: Resident interviews on 12/18/17 identified the	F 657	1. Three interventions that were being done but had not been documented regarding resident #5's hollering behaviors were added to the care plan on 12/21/17. 2. Any residents with behaviors that affect others have the potential to be affected by this practice. 3. A meeting of the activity/social service staff was held on 1/10/18 and additional interventions were identified to add to resident #5's care plan. 4. QA will be completed by the Resident Care Coordinator or her designee monthly for three months and quarterly thereafter for the remainder of the year to ensure residents with behaviors affecting	

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F 657	Continued From page 16 following: * At 3:20 p.m. Resident #29 stated Resident #5 often makes sounds at night "like a truck climbing a hill." * At 4:09 p.m. Resident #23 expressed concerns with Resident #5. "He yodels and yells at night. He thinks he's an engine. There's nothing that can be done about it." Both residents stated these noises at times kept them from sleeping and stated they had informed staff who stated nothing could be done about it. Observations on 12/19/17 at 3:15 p.m. showed Resident #5 making grunting sounds which could be heard several doors down the hall and at 3:39 p.m. Resident #5 was hollering loudly "Whoo, Whoo!" Resident #5's medical record, reviewed on December 19-20, 2017, identified diagnoses including schizophrenia - paranoid type. A quarterly Minimum Data Set, dated 09/14/17 identified the resident with severe cognitive impairment and behaviors that had no effect on others. Progress notes showed the following: * 09/03/17 at 9:52 p.m.: "CNA [Certified Nursing Assistant] reported [Resident #5] has been intermittently making shrill loud outbursts all PM [evening] shift like he does every now and then. Denies pain. Has been cooperative and now to bed." * 09/04/17 at 9:19 p.m.: "Resident has been calling out loudly, repetitious statements. Speaking in high shrill voice. . . ." * 09/21/17 at 9:37 p.m.: ". . . resident has been loud tonight singing . . . asked resident to soften	F 657	others have multiple interventions identified to implement when the behavior is displayed.	

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F 657	Continued From page 17 voice and closed his door. . . resident did soften voice down for a while but came back loud repeated several times. . . ." The record indicated this behavior lasted for four hours. * 12/14/17 at 3:36 p.m.: ". . . resident has been loud all shift . . . resident was left in his room . . . d/t [due to] being loud . . ." The record indicated this behavior lasted six hours. Review of Resident #5's current care plan identified one intervention for staff to implement for the behaviors: "Staff will assist to [sic] me to my room to draw at my desk if I do not respond to reorientation and re-direction and if I become distrubtive [sic] to others. . . ." An interview with an administrative nurse (#1) occurred on 12/20/17 03:15 p.m. regarding Resident #5's behavior plan. When asked, the nurse (#1) failed to supply additional information indicating staff developed further interventions for Resident #5's disruptive behaviors.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/23/2016	F 689	1. A reminder about the proper use of gait belts was put into shift-to-shift report for nursing staff. The Nursing Services	1/26/18

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F 689	Continued From page 18 Based on observation, review of facility procedure, review of a professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 1 sampled residents (Resident #31) observed during a gait belt transfer. Failure to properly use a gaitbelt during transfers placed the residents at risk of accidents and injury. Findings include: Review of the facility procedure for "Transferring a resident from bed to wheelchair" occurred on 12/20/17. This procedure stated, ". . . Place the transfer belt around resident's waist over clothing. . . . Tighten the buckle until it is snug. Leave enough room to insert flat fingers/hand comfortably under the belt. Check to make sure that skin or skin folds (for example, breast) are not caught under the belt. . . ." Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, Pearson Education, Inc., New Jersey, page 1054, stated, "Assisting a Client to Ambulate . . . If the client is a low safety risk . . . use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ." During an observation on 12/19/17 at 7:42 a.m.; two CNAs (#2 and #3) transferred Resident #31 from the toilet to wheel chair (W/C) with assist of two and a gait belt. During the transfer, the gait belt slid up the resident's upper back. Staff failed	F 689	Coordinator provided education for two days at shift-to-shift reports the week following the survey. 2. All residents who need assistance with transfers using a gait belt have the potential to be affected. 3. Education will be provided on January 22nd for nurses, med aides, and C.N.A.'s regarding proper use of gait belts. Education was provided to Case Managers (activity/social service staff) regarding proper use of gait belts on January 10th, 2018. 4. QA will be completed by the MDS Coordinator (or her designee) weekly for two weeks, then monthly for two months, and quarterly thereafter for the remainder of the year to ensure gait belts are used properly.	

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F 689	Continued From page 19 to tighten or readjust the gait belt for the transfer. During an observation on 12/19/17 at 4:44 p.m.; two CNAs (#4 and #5) applied a gait belt loosely under Resident #31's breasts and transferred her from the recliner to the W/C. The gait belt slid up the resident's back and pulled up under the resident's breast with standing. The resident complained of her breasts being "squished" with the gait belt during the transfer. The staff failed to tighten or readjust the gait belt. During an interview on 12/20/17 at 3:36 p.m., an administrative nurse (#1) stated she would expect staff to tighten the gait belt if loose during transfers.	F 689		