STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY LEGACY HOME	100 19TH ST WHEATLAND, WY 82201

(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 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to immediately notify the resident's physician when there was a significant	F 157	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5/23/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 change in the resident's condition which had the potential for requiring physician intervention or a need to alter the treatment plan. This was identified for two of 11 sampled residents (#10 and #1) who had documented changes in their condition which included staff holding resident medications and notification of a resident having low glucose levels. The findings included: 1. Medical record review for resident #10 evidenced that the resident had diagnoses that included Alzheimers, congestive heart failure, essential (primary) hypertension and osteoporosis. On 4/12/16 at 12:05 PM, during a medication pass observation with nurse (A), she was observed to prepare and administer seven medications to resident #10. According to the Medication Administration Record (MAR), these seven medications were scheduled to be given at 8:00 AM. The nurse commented that the resident "was asleep this morning so we give them (the medications) when she is awake." Review of the resident's April, 2016 MAR for 4/1/16 through 4/13/16 revealed the following 8:00 AM medications were charted as "N" or "Not Administered" on 4/3, 4/4, 4/5, 4/7, 4/9, 4/10, and 4/11/16: Hydrochlorothiazide (diuretic used for hypertension and edema) 25 mg daily Ramipril (antihypertensive) 10 mg daily Multivitamins daily Omeprazole (antiulcer) 20 mg daily	F 157	F157- On 4/20/16 physician reviewed current medications and vitals and adjusted medications for resident #10. Resident #10 was put on comfort care on 5/6/16. Resident #10 has physician orders to attempt to administer medications when resident is awake. The policy and procedure for medication administration and notifying physician was updated on 5/17/16 to require staff to notify physician and document physician recommendations when medication has not been administered. Staff were educated on the policy and procedure on 5/18/16. An audit was conducted by DON and or designee on 5/17/16 on all residents of non-administered medications for the last month to ensure physicians were notified. Audits will be conducted by the DON or designee using an audit tool of all non-administered medications weekly times 4 weeks and monthly thereafter to ensure physicians are being notified. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly	5/26/16

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F 157	Continued From page 2 Atenolol (antihypertensive) 12.5 mg daily Amlodipine (antihypertensive) 5 mg daily Tylenol EX-STR 1000 mg twice a day. Review of the resident's Administration Record evidenced documentation that the resident refused or was asleep for the above doses that were charted as not given. On 4/14/16 at 9:00 AM, this resident's medication issues were discussed with the Director of Nursing (DON). There was no evidence found to show that the physician was notified of this resident's medications not being administered for multiple days. 2. Medical record review for resident #1 revealed diagnoses that included hypertension, fractured femur, and type 2 diabetes. Review of the resident's April, 2016 MAR evidenced that the resident had an 11/17/15 order for "Blood glucose check twice weekly fasting on Tuesday and Friday". No parameters were noted to indicate when the physician should be called for abnormal glucose levels. Review of log sheets listing the resident's blood glucose levels from 11/3/15 to 4/8/16 noted the following glucose levels which were 60 or below: 12/18/15 6:27 AM "low" 12/29/15 5:42 AM "57"	F 157	thereafter for one year for further review and analysis. Physician was notified of Resident #1 low glucose levels on 4/15/16. As resident was asymptomatic there were no changes in orders or plan of care. The policy and procedure for glucose levels, reporting parameters, and notifying physician with input from the medical director was updated on 5/10/16. Staff was educated on the policy and procedure by 5/17/16. An audit was conducted by 5/17/16 of all residents receiving glucose monitoring of the last three months to ensure physician was notified of low levels. Audits will be conducted by DON or designee using an audit tool of all diabetic resident's finger stick glucose levels weekly times 4 weeks and monthly thereafter to ensure physicians are being notified of low levels. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	

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F 157	Continued From page 3 3/4/16 5:50 AM "Low" 3/22/16 5:50 AM "Low" 3/29/16 5:51 AM "Low" 4/5/16 5:26 AM "46". Review of the Department Notes evidenced that the following nurse actions on the morning when the blood glucose levels were below 60. 12/18/15 - no note was written between 2:59 AM and 2:29 PM. 12/29/15 - no note was written between 12/28/15 8:26 PM and 12/29/15 1:25 PM. 3/4/16 - no note was written between 3/3/16 3:25 PM and 3/4/16 11:34 AM. 3/22/16 6:14 AM - "Resident's blood sugar at 0600 (6:00 AM) was 71 asymptomatic given granola snack bar and orange juice with sugar, will continue to monitor." (Note: The blood sugar at 5:50 AM was "low". It was unclear if the 71 was the recheck after the snack.) 3/29/16 6:33 AM -"Checked ___(resident's name) blood sugar at 0600 and was 66 given orange juice with 2 packs sugar and snack cereal. Resident asymptomatic. Will monitor." (Note: The blood sugar at 5:51 AM was "low". It was unclear if the 66 was the recheck after the snack.) 4/5/16 5:51 AM ' "Fasting FBSB-46. Given orange juice and granola bar. Resident AAOx3 (alert and	F 157		

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F 157	Continued From page 4 oriented)." On 4/14/16 at 9:00 AM, this resident's blood sugar levels, the lack of parameters, and the lack of physician notification were discussed with the Director of Nursing (DON). There was no evidence to show that these blood sugar levels were reported to the physician.	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide care in a manner which enhanced the residents' self-worth and individuality while they were eating their meals in the dining room. The findings included: 1. On 4/12/16 during the noon meal, the following observations were made: At 12:35 PM while resident #22 was being assisted to eat, she coughed and spit up some food. The Certified Nurse Aide (CNA) (B) held the clothing protector up in front of the resident's face. The CNA continued to hold this protector up, so that the resident's entire face was not visible when standing in front of her. The CNA was standing while assisting the resident with her	F 241	F241- The dining room has been rearranged to enable staff to assist residents 10,22,23,24, and 25 with meals in a more dignified and respectful manner. All staff including CNA B were educated on 5/10/16 on dignity and respect to enhance resident worth and individuality. Utilizing an audit tool, audits will be conducted by the DON or designee on all meals for two weeks or until compliance is maintained and then weekly thereafter for two months and monthly thereafter. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	5/26/16

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F 241	Continued From page 5 meal. Staff were attempting to get resident #10 awake so that she could eat and take her medications. The resident was observed to spit out mucous. The nurse (A) reported that the resident had sneezed. The CNA attempted to give the resident another drink. The resident's clothing protector was held (closely) up in front of the resident's face in such a manner that her face could not be seen from in front of her. 2. On 4/14/16 during the noon meal, CNA (B) was observed standing to assist residents #22 and #24 who were seated at table 12. The other two residents who were also seated at this table were not served their food for at least twenty minutes. One of these two residents (#23) needed assistance, while the other one (#25) was able to feed herself. CNA (B) was observed standing to assist resident (#23). 3. An interview with the DON, on 4/14/16 during the noon meal after observing CNA (B) standing to assist residents, was done. The DON reported that staff was not supposed to be standing to assist and feed residents and staff had been educated on how to assist residents. The DON was then observed to instruct CNA (B) about sitting to assist the residents. The CNA was then observed to get a stool and sit by the resident. The surveyor left the dining room for a short time to watch a room tray being delivered to a resident room. Upon return to the dining room CNA (B) was again observed standing to assist and feed residents.	F 241		
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS	F 274		

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F 274 SS=D	Continued From page 6 AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to perform significant change Minimum Data Set (MDS) assessments when the residents had significant improvements in their conditions. This failure involved two of 11 sampled residents (Resident #6 and #1). The following are the criteria for significant changes based on improvement: o Any improvement in ADL assistance where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8; o Change in behavior or other symptoms is coded as "improved"; o Decrease in the areas indicating sad or anxious mood as a problem as indicated by symptom	F 274	F274- Significant changes were completed on Residents #1 and #6 on 5/6/16. Audits will be conducted by MDS Coordinator or designee using an audit tool will compare resident's current status to the most recent comprehensive assessment and subsequent quarterly assessments to determine if a significant change has occurred requiring a significant change in the MDS. MDS Coordinator was educated on 5/10/16 on CMS's RAI version 3.0 manual on significant change in status assessment. An auditing tool has been developed to monitor improvements in ADLs, improvements in behavior, resident decision making, and incontinence. Auditing tool will be reviewed by the MDS Coordinator or designee weekly times 4 weeks and monthly thereafter to ensure significant improvement change of conditions are appropriate. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	5/26/16

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F 274	Continued From page 7 presence and frequency, or total severity score, on the MDS o Resident's decision making changes from 2 or 3, to 0 or 1; o Resident's incontinence pattern changes from 2 or 3 to 0 or 1; or o Overall improvement of resident's condition; resident receives fewer supports. The findings included: 1. Record review for resident #6 revealed that the resident was admitted on 8/17/15 and had diagnoses that included depression, anxiety state, cardiac disease with a pacemaker, hypertension, and diabetes type II. a. Review of the resident's 2/18/16 and 11/19/15 quarterly MDS assessments evidenced the following improvements in functioning: 2/16 - Resident's BIMS Score was 15, showing that the resident was cognitively intact. 11/15 - Resident's BIMS Score was 11, showing that the resident's cognition was moderately impaired. 2/16 - Resident's depression score showed minimal depression. 11/15 - Resident's depression score showed moderate depression. 2/16 - Resident's urinary continence status was occasionally incontinent. 11/15 - Resident's urinary continence status was frequently incontinent.	F 274		

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F 274	Continued From page 8 2/16 - Resident required supervision with bathing. 11/15 - Resident required physical help with bathing. b. Review of the resident's 11/19/15 quarterly and 8/24/15 admission MDS assessments evidenced the following improvements in functioning: 11/15 - Resident required supervision with locomotion on unit. 8/15 - Resident required extensive assistance with locomotion on unit. 11/15 - Resident required supervision with locomotion off unit. 8/15 - Resident required extensive assistance with locomotion off unit. 11/15 - Resident required supervision with toilet use. 8/15 - Resident required extensive assistance with toilet use. 11/15 - Resident required supervision with personal hygiene. 8/15 - Resident required extensive assistance with personal hygiene. No significant change of condition re-assessments were found for this resident. On 4/14/16 in the afternoon, in an interview with MDS Coordinator, he verified that he had not done significant change assessments for improvements in condition for any residents. He indicated his focus for significant change MDS reassessments was on declines.	F 274		

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F 274	Continued From page 9 There was no evidence that the resident's change of status was recognized as a significant change or that a full comprehensive re-assessment was completed. 2. Record review for resident #1 revealed that the resident was re-admitted on 11/17/15 and had diagnoses that included diabetes type II, congestive heart failure, hypertension, and fractured femur. a. Review of the resident's 2/23/16 quarterly and 11/24/15 significant change MDS assessments evidenced the following improvements in functioning: 2/16 - Resident's depression score showed minimal depression. 11/15 - Resident's depression score showed mild depression. 2/16 - Resident required limited assistance with bed mobility. 11/15 - Resident required extensive assistance with bed mobility. 2/16 - Resident required limited assistance with transfer. 11/15 - Resident required extensive assistance with transfer. 2/16 - Resident required supervision with locomotion on unit. 11/15 - Resident required extensive assistance with locomotion on unit. 2/16 - Resident required supervision with locomotion off unit. 11/15 - Resident required extensive assistance	F 274		

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F 274	Continued From page 10 with locomotion off unit. 2/16 - Resident required limited assistance with toilet use. 11/15 - Resident required extensive assistance with toilet use. 2/16 - Resident required limited assistance with personal hygiene. 11/15 - Resident required extensive assistance with personal hygiene. 2/16 - Resident's bowel continence status was continent. 11/15 - Resident's bowel continence status was frequently incontinent. No significant improvement change of condition re-assessment was found for this resident. The failure to re-assess residents with significant improvements can result in care plans that do not represent the needs of the residents. These care plans do not provide staff with interventions that encourage maintaining or continuing improvements for the residents.	F 274		
F 280 SS=E	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 within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		

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F 280	Continued From page 11 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, medical record review, and staff interviews, the facility failed to ensure residents' plans of care were evaluated and revised to meet residents' individual needs. This was identified for four of 11 sampled residents (# 7, #9, #4, and #3). The findings included: 1. Resident #7's medical record review revealed the resident had been admitted to the facility on 1/4/10. The resident's diagnoses included; COPD (chronic obstructive pulmonary disease), muscle weakness, impaired vision and dysphagia. The resident was recently readmitted to the facility from the hospital for the second time on 3/22/16 with the "multiple drug resistant pneumonia and dysphagia". a. Review of the discharge summary from the hospital also noted, "The resident was on pureed food, thickened liquids and thin water.	F 280	F280- Resident #7 care plan was updated to reflect current condition on 5/6/16. Resident #7 has since passed away. Resident #9 care plan has been updated to reflect current condition on 5/6/16. Resident #4 care plan has been updated to reflect current condition on 5/6/16. Resident #3 care plan has been updated to reflect current condition on 5/6/16. A Change of Condition log was implemented on 5/12/16 to ensure care plans are being updated timely. Staff were educated on 5/12/16 on the Change of Condition log and care plans and dating interventions. All remaining resident's care plans will be reviewed by DON or designee to ensure they meet the resident's individual needs by 5/18/16. The change of condition log will be audited weekly by the DON or designee to ensure care plans are updated correctly and dated with reports submitted to QA&A monthly. Utilizing an audit toll, audits will be conducted by the DON or designee of care plans to ensure they meet the resident's individual needs weekly times 8	5/26/16

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F 280	Continued From page 12 Dehydration/malnutrition both will be a challenge to improve given his swallowing issues". b. Review of the microbiology report from the sputum dated 4/7/16 showed the resident to have a moderate growth of methicillin resistant staphylococcus aureus, MRSA. [Note: MRSA is methicillin-resistant Staphylococcus aureus, a type of staph bacteria that is resistant to many antibiotics. In a healthcare setting, such as a hospital or nursing home, MRSA can cause severe problems such as bloodstream infections, pneumonia and surgical site infections.] c. Review of the charge nurse's note dated 3/30/16 identified the resident as being on "Droplet Precautions" and the resident requiring set up help and supervision during meals. A CNA to stay with him while he eats in case he chokes." d. During the survey the resident was observed to be in "Droplet Precautions" which the staff reported was due to the resident having MRSA infection. e. Review of the resident's plan of care found the plan of care had not been revised and updated to show the resident having MRSA or the resident needing one person assist with eating due to his increased risk for choking. 2. Resident #9's medical record revealed the resident was admitted to the facility on 5/29/15.	F 280	weeks and monthly thereafter until compliance is maintained. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	

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F 280	Continued From page 13 The resident's diagnoses included: Alzheimer's disease, hypertension, diabetes, depression other than bipolar, osteoporosis and GERD (gastro-esophageal reflux disease). a. Review of the resident's current MAR (medication administration record) for April 2016 showed the resident was on and number of medications. Some of the medications included: Sertraline (Zoloft), 50 mg one tablet daily, (an antidepressant medication), Namenda XR 28 mg capsule every night, Zyprexa 2.5 mg tablet one tablet every evening, (an antipsychotic medication), Melatonin 3 mg one tablet at bedtime, Oxybutyin 5 mg tablet 1/2 tab (2.5 mg) twice a day for bladder spasms. b. Review of the "Psychotropic Drug Review Form" included the following: -11/9/15 -"Maybe DC Namenda? Aricept?" -physician follow up-"Will discontinue Aricept and increase Zoloft to 50 mg. Start Zyprexa 2.5 mg again every HS d/t (due to) behavior and mood changes after stopping". -11/29/15 -"Just started Seorquel and had increase in Zoloft. Monitor closely for any signs of adverse effects as well as determining if mood is improved it's important to document in order to determine best dose."	F 280		

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F 280	Continued From page 14 -12/31/15 -"Still need documentation for behavior on new dose of Seroquel and Sertraline." -3/29/16 -"Zyprexa 2.5 mg HS (11-2015), Sertraline 50, Namenda XR 28, admitted 5-2015 on Zyprexa off Sept. and Nov. hallucinations resumed(?)", -Physician follow up- "On less Zyprexa now and recently (sign) trail of wean off, continue meds as is, risk (greater than sign >) benefit of wean again". c. Review of the resident's plan of care identified: Problem - "potential for toxicity, adverse reactions or side effects and injury due to the use of psychotropic medications. She takes Setraline (Zoloft), an antidepressant." [Note the plan of care was not updated to address the other psychotropic mediations.] Goal- (Resident name) will display no signs of toxicity, adverse reactions from use of psychotropic medications over next 90 days. (date 11/28/15) Approaches- -"Evaluate effectiveness and side effects of the medications for possible / elimination of psychotropic drugs every 90 days and record on Psychotropic Drug Review Form. Monitor (name) for side effects for the medication Sertraline including dry mouth, loss of appetite, weight loss, mild diarrhea, constipation, nausea, vomiting, sleepiness, or trouble sleeping.	F 280		

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F 280	Continued From page 15 Monitor (name) bowel elimination pattern and report any abnormalities to physician. Follow constipation protocol as needed. Monitor (name) mental status functioning on an ongoing basis. Report any changes to via the Stop and Watch form for follow up." The resident's plan of care had not been updated with the use of antipsychotic medications (Zyprexa). d. Interview with the DON on 4/15/16 confirmed the facility had no documentation to show the ongoing monitoring of behaviors and side effects for the use of an antipsychotic for this resident. e. This resident was also identified as having a fall with injury on 3/10/16. The resident fell while using her walker and sustained a laceration to her nose and abrasion to the left eye. The CT (computed tomograghy) of her head showed a nasal bridge fracture.) The care plan had identified the resident as being at risk for falls on 1/19/16 to 5/25/16. However the fall and nasal fracture had not been update nor any additional interventions to address falls. 3. Medical record review for resident #4 evidenced that the resident was admitted on 12/4/13 with diagnoses that included dementia with behavioral disturbances, diabetes type II, and depressive disorder. The resident had a Fall Risk assessment done on 2/12/16 with a score of 20 (high risk for falls).	F 280		

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F 280	Continued From page 16 Review of the resident's incident reports revealed the following falls: 2/22/16 - Found on the floor in resident room. The immediate post-incident action was "encouraged to use call light when getting out of bed".The narrative of investigation noted that the resident "Has abrasion to left big toe. CNA reports is walking steady today. Gripper socks on, toileted at 2 am. He has hx of dementia and doesn't remember to use call light and occasionally will attempt to self transfer. He has a paddle call light in his room but it did not trigger with his movement. Staff will be prompted for placement of paddle to detect movement. Resident is on scheduled rounding." 3/14/16 - Fall/no head injury in resident room. The immediate post-incident action was "gripper socks applied". The narrative of investigation noted that the resident "...was observed on the floor in his room. He stated he was attempting to get to the bathroom. ....should have gripper socks on when he is readied for bed, this was communicated and care planned. He is on scheduled rounding for fall risk." Review of the resident's care plan evidenced a problem which included the statement "I am a fall risk because I am unsteady & I take some medications that might make me dizzy." The Goal & Target Date for "I will have no falls requiring medical tx." The target dates listed are 11/27/15, 3/19/16, and 5/13/16. Undated Approaches included: "Assist me when it looks like I am unsteady or weak with ambulation -." A note written next to this approach and dated 2/18/16 indicated "I	F 280		

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F 280	Continued From page 17 mostly use a w/c (wheelchair)" "If I am sliding down in my chair help me get to sitting up straight." "I need non-skid socks at night, check on my nightly rounds to be sure I have them on." "I have a landing strip by my bed when I am in it." "I should have assistance x 1 with gait belt when attempting to walk." This note was hand written but not dated. On 4/15/16 in an interview with the Director of Nursing, (DON), she was requested to provide evidence of the care plan changes that were made after the resident had the fall on 2/22/16 and on 3/14/16. She provided Page 4 of the resident's care plan with the Target Date highlighted (5/13/16) and the Approach of "I need non-skid socks at night". There was no date to show when this intervention was added (Note: It was not hand written as other additions were.) The use of gripper socks was an intervention that was already present as described in the 2/22/16 narrative. The use of the paddle call light was not included in the care plan related to falls. 4. Medical record review for resident #3 revealed that the resident was re-admitted on 3/14/16 with diagnoses that included Parkinson's disease, hypertension, depressive disorder, and multiple fractures of ribs on left side. Review of the resident's 3/24/16 significant change MDS assessment evidenced that the resident had a BIMS of 15 (cognitive intact), required extensive assistance for the performance of his ADLs (activities of daily living), and had experienced a	F 280		

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F 280	Continued From page 18 fall with a fracture since the last MDS assessment (1/15/16). Review of the 4/8/16 "Care Plan Conference Summary" for this resident noted the resident was "high fall risk, 2/13/16 major injury, broken ribs". a. Review of the resident's care plan noted that the resident had a Fall Risk Evaluation with a score of 16. The goal was "I will not have any falls over the next 90 days with target dates of 1/16/16 (not met) and 4/21/16." Falls were noted as occurring on 11/29/15, 12/3/15, 12/12/15, and 12/26/15. There was no evidence on the care plan to show updates were done after each of these falls or after the fall with the fractures ribs and hematoma. Review of the facility's "Daily Assignment Sheet", updated on 4/12/16, for this resident, documented that the fall risk was high as the resident "self transfers, doesn't always remember call light". The line for recent falls was blank. On 4/15/16 in an interview with the DON, she was requested to provide evidence of the care plan changes that were made after the resident had falls and for 3/18/16 tracking for a wound. The DON responded that there was no wound but the notes were about bruising related to the abdominal hematoma. No additional care plan approaches were identified for this resident's falls. b. Review of the 1/21/16 "Care Plan Conference Summary" for this resident noted the resident had a significant weight loss with a decrease of 10% in 180 days. Review of the 4/8/16 "Care Plan Conference Summary" for this resident noted the resident had a significant weight loss in 30 days	F 280		

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F 280	Continued From page 19 and 180 days. Review of the resident's 3/14/16 admission orders evidenced an order for regular diet - mechanically altered. A 3/30/16 order was for the resident to receive a "Nutritional supplement Ensure Plus 240 ml po (oral) between meals TID (three times a day)". Review of the resident's current care plan does not include the mechanically altered diet or the supplements. Review of the facility's "Daily Assignment Sheet", updated on 4/12/16, for this resident, documented that the resident was to receive a regular diet and to cut his food before bringing it to the table. There was no information about the mechanically altered food or the between meal supplements.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, it was determined that the facility failed to follow professional standards and facility policies when administering medications and failed to ensure that physician orders were followed for two of eleven sample residents (#10 and #7) and one supplemental resident (#19). The findings included: 1. Medical record review for resident #10	F 281		

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F 281	Continued From page 20 evidenced that the resident had diagnoses that included Alzheimers, congestive heart failure, essential (primary) hypertension and osteoporosis. a. On 4/12/16 at 12:05 PM, during a medication pass observation with nurse (A), she was observed to prepare and administer seven medications to resident #10. Five of the seven medications were crushed and two were capsules that were opened. All of these were put into chocolate pudding. According to the Medication Administration Record (MAR), these seven medications were scheduled to be given at 8:00 AM. The nurse commented that the "she was asleep this morning so we give them (the medications) when she is awake". b. On 4/13/16 the Director of Nursing (DON) provided the Medication Administration Time Guidelines (facility policy for times to give the medications). The policy noted that AM = 0630 - 1030 (6:30 AM to 10:30 AM) and "If any meds are given outside of the guidelines please note the time on the MAR and make a notation in the PRN sheet." The nurse initialed the MAR that she administered the medications but did not indicate that the medications were given at 12:05 PM, instead of 8:00 AM. The nurse failed to follow the facility policy. c. Review of the resident's April, 2016 MAR for 4/1/16 through 4/13/16 revealed the following 8:00 AM medications were charted as "N" or "Not Administered" on 4/3, 4/4, 4/5, 4/7, 4/9, 4/10, and 4/11/16: Hydrochlorothiazide (diuretic used for hypertension and edema) 25 mg daily	F 281	F281- Physician contacted on 4/13/16 and clarified order to crush medications for resident #10. On 4/20/16 physician reviewed current medications and vitals and discontinued the Hydrochlorothiazide, Ramipril, Atenolol, and Amlodipine. As of 5/6/16 resident #10 is on comfort care and orders received ok to give medications upon arising. Resident #7 is deceased. Resident #19 will have nursing staff present for all medication administration to ensure she is taking the medication safely. The policy and procedure for medication administration was updated on 5/16/16. Administering medication through a small volume nebulizer policy and procedure was updated on 5/10/16 to include that the resident is assessed before and after treatments or as physician orders. Staff was educated on the policy and procedure for small volume nebulizers medication administration by 5/18/16. All nurses will have competencies on appropriate medication administration techniques by	5/26/16

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F 281	Continued From page 21 Ramipril (antihypertensive) 10 mg daily Multivitamins daily Omeprazole (antiulcer) 20 mg daily Atenolol (antihypertensive) 12.5 mg daily Amlodipine (antihypertensive) 5 mg daily Tylenol EX-STR 1000 mg twice a day. d. Review of the resident's Administration Record evidenced documentation that the resident refused or was asleep for 49 of 91 doses that should have been administered. e. On 4/14/16 at 9:00 AM, in an interview with the Director of Nursing (DON), the failure to follow physician orders was discussed. (Cross refer to F157 for failure to notify the physician that the medications were not given as ordered) f. Review of the resident's physician orders revealed no order to crush her medications. In the interview with the DON, she said she would look for the order to crush meds. The DON brought the surveyor an order, dated 4/13/16, to clarify that the resident was to continue to receive crushed meds. Breathing Treatments: 2. Resident # 7's medical record review revealed the resident had been admitted to the facility on 1/4/10. The resident's diagnoses included COPD (chronic obstructive pulmonary disease), muscle weakness, impaired vision, and dysphagia. The	F 281	5/17/16. Random audits will be conducted of medication administration by the DON or designee weekly times 8 weeks and monthly thereafter until compliance is maintained. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	

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F 281	Continued From page 22 resident was recently readmitted to the facility from the hospital for the second time on 3/22/16 with "multiple drug resistant pneumonia and dysphagia". a. Review of the discharge summary from the hospital also noted, "The resident was on pureed food, thickened liquids and thin water. Dehydration/malnutrition both will be a challenge to improve given his swallowing issues." b. Review of the microbiology report from the sputum dated 4/7/16 showed the resident to have a moderate growth of methicillin resistant staphylococcus aureus, MRSA. c. Review of the charge nurses notes included: - 3/30/16 identified the resident as being on "Droplet precautions" and the resident requiring set up help and supervision during meals. A CNA to stay with him while he eats in case he chokes." -4/9/16 2:10 AM - "Resident had an episode of nausea and vomiting during his nebulizer tx. Last evening after dinner. He was yelling "Help me! Help me!". I went into room and he was gagging on phlem that was in his throat and mouth. He kept spitting and gasping until he got it out of his throat and could spit in the basin. He was very pale. CNA came in and saw that his O2 was not (sig- as not) connected to his concentrator. He put resident's O2 on him. Resident was starting to breathe (sig) better. No more coughing up phlem. Resident was able to lie down. He said he felt much better and thanked us for coming to help him. Resident is on rounding for safety and comfort. He has his O2 on at this time. Call light and water are in reach."	F 281		

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F 281	Continued From page 23	F 281		

d. Review of the resident's current MAR (medication administration record) for April 2016 showed, the resident was on Duo Nebulizer treatment three times per day 6:00 AM, 2:00 PM, and 10:00 PM. Also on PRN (as needed) Duo Neb treatments up to four times a day.

e. Observation on 4/14/16 at 12:40 PM the resident had call light on and was heard asking CNA for a breathing treatment. The resident was noted to be in "Droplet precautions" for MRSA.

At 12:50 PM the CNA set up the resident's food tray on the bedside table. The CNA was heard telling the Resident, "I will come back to help you when you are finished with your breathing treatment." As the CNA came into the hall she reported to the surveyor the resident was doing his breathing treatment and she would be back to check on him when he could eat. The nurse was not in the room during the breathing treatment.

f. The nurse for the resident was at the nurse's station at the medication cart. She was asked if she stayed with the resident during his breathing treatments. She reported that the resident could do it by himself and she would go back later to check on him.

g. The DON was then asked about doing Nebulizer/breathing treatments. She reported that it was her expectation that the nurse should be staying with the resident during his treatment to ensure it was done correctly and assess the resident before and after the treatments. The DON then went to the nurse and asked her about doing the treatment. The nurse reported to the DON she was not staying with the resident during

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F 281	Continued From page 24 his breathing treatments. The DON instructed the nurse to be staying with the resident during the treatment to ensure care and reminded the nurse the resident was on skilled level of care. Medications left at the table: 3. Observation were made during breakfast in the dining room on 4/14/16 at 9:20 AM. The nurse (C) was noted to leave medication sitting in front of resident #19. She instructed the resident to take her medication when she was done eating. The nurse then returned to the other end of the dining room where she had her medication cart. The nurse had her back to the residents as she continued to set up and prepare other residents' medications. The nurse did not observe the resident take her medications. The resident was seated next to another resident at the table. Review of resident #19's medical record revealed that the resident was assessed to have severe cognitive impairment with a BIMS of 3. This resident was not able to safely self-administer her own medications.	F 281		
F 309 SS=E	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 accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to provide care in a manner to ensure adequate and appropriate diabetic monitoring and treatment for one of ten sample residents (#1) who received insulin. This failure could affect the resident's ability to reach his highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: 1. Medical record review for resident #1 revealed diagnoses that included hypertension, fractured femur, and type 2 diabetes. a. Review of the resident's physician orders for insulin revealed the following orders: 6/10/15 - Lantus decrease to 16 units every evening, discontinued 10/25/15. 10/25/15 - Lantus 25 units QHS, discontinued 10/26/16. Out of facility, returned 11/2/15 from hospital stay. 11/2/15 - Lantus 20 units QHS, discontinued 11/9/15. Out of facility, returned 11/17/15 from hospital stay. 11/18/25 - Lantus 20 units every evening, discontinued 11/25/15. 11/25/15- Lantus increase to 23 units Q HS (every bedtime).	F 309	F309- Physician was notified of Resident #1 low glucose levels on 4/15/16. No changes were made in the residents plan of care. An updated policy and procedure was put in place for blood glucose monitoring and physician notification parameters on 5/10/16. Nurses were educated on 5/12/16 on proper glucose monitoring techniques and physician notification parameters when blood glucose levels are less than 50 and greater than 500. An audit was conducted using an audit tool by DON or designee on 5/18/16 of all diabetic residents of the last three months to ensure physician was notified of low levels. Audits will be conducted using an audit tool by DON or designee of all diabetic resident's weekly times 4 weeks and monthly thereafter to ensure physicians are being notified of low levels according to the policy. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	5/26/16

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	535053	A. BUILDING _____ B. WING _____	04/15/2016

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b. Review of the resident's April, 2016 MAR evidenced that the resident had an 11/17/15 order for "Blood glucose check twice weekly fasting on Tuesday and Friday". No parameters were noted to indicate when the physician should be called for abnormal glucose levels.

c. Review of log sheets listing the resident's blood glucose levels from 11/3/15 to 4/8/16 noted the following glucose levels which were 60 or below:

12/18/15 6:27 AM "low"

12/29/15 5:42 AM "57"

3/4/16 5:50 AM "Low"

3/22/16 5:50 AM "Low"

3/29/16 5:51 AM "Low"

4/5/16 5:26 AM "46".

d. Review of the Department Notes evidenced that the following nurse actions on the morning when the blood glucose levels were below 60.

12/18/15 - no note was written between 2:59 AM and 2:29 PM.

12/29/15 - no note was written between 12/28/15 8:26 PM and 12/29/15 1:25 PM.

3/4/16 - no note was written between 3/3/16 3:25 PM and 3/4/16 11:34 AM.

3/22/16 6:14 AM - "Resident's blood sugar at 0600 (6:00 AM) was 71 asymptomatic given granola snack bar and orange juice with sugar,

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F 309	Continued From page 27 will continue to monitor." (Note: The blood sugar at 5:50 AM was "low". It was unclear if the 71 was the recheck after the snack.) 3/29/16 6:33 AM -"Checked ___(resident's name) blood sugar at 0600 and was 66 given orange juice with 2 packs sugar and snack cereal. Resident asymptomatic. Will monitor." (Note: The blood sugar at 5:51 AM was "low". It was unclear if the 66 was the recheck after the snack.) 4/5/16 5:51 AM ' "Fasting FBSB-46. Given orange juice and granola bar. Resident AAOx3 (alert and oriented)." e. On 4/15/16 at 8:40 AM, in an interview with nurse (D), she provided a copy of the Assure Platinum Blood Glucose Monitoring System information. This was the glucometer which was used for glucose testing on resident #1. In the Troubleshooting & Customer Service section of this document, LO was noted to indicate that "Your blood glucose level is less than 20 mg/dL. Repeat the test using a new test strip. If this message appears again, contact a healthcare professional immediately." 2. On 4/15/16 at 9:23 AM, this resident's blood sugar levels, the lack of parameters, and the lack of physician notification were discussed with the Director of Nursing (DON). A copy of the facility's policy for diabetic management was requested. At 9:42 AM, the DON verified that the facility did not currently have a policy/system in place for parameters for glucose monitoring.	F 309		
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311		

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F 311 SS=E	Continued From page 28 IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to provide adequate meal assistance to three of 11 sample residents (#2, #3, and #4) and seven supplemental residents (#21, #26, #27, #29, #18, #19, and #20). These residents were facility assessed and/or observed to be able to feed themselves all or part of his/her meals, but required supervision, cueing, and/or physical assistance to eat. The findings included: 1. On 4/12/16 during the noon meal, the following observations were made: The meal included country oven chicken, potatoes, oriental vegetables and mousse. a. Table #5 had two resident (#2 and #20) seated at the table in wheelchairs and were served at 12:05 PM. Resident #2 was served a pureed diet. The resident were observed to look around the dining room and made no attempt to eat and was not cued until 12:30 PM by the nurse who encouraged resident #2. She then cut up resident #20's chicken. Both residents were then observed to eat a few bites of food and stop. The residents were not offered any further cueing and assistance until they were assisted out of the dining room at 1:00 PM.	F 311	F311- Dining room seating has been rearranged to better provide assistance to residents 2,3,4,19,20,21,26,27,29. Staff was educated on providing appropriate and timely assistance including cuing for residents in the dining room on 5/10/16. A monitoring tool has been implemented for the dining room to ensure that residents are receiving the appropriate and timely assistance with meals. Administrator or designee will conduct audits of the dining room using the monitoring tool daily times two weeks until compliance is maintained and then weekly thereafter for two months and monthly thereafter. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	5/26/16

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F 311	Continued From page 29 b. Table #7 had resident #4 who was served at 12:15 PM. He was not eating and was not cued until 12:52 PM when the nurse cut up the resident's chicken. The resident then ate approximately 50% of his meal. c. Table #6 noted resident #21 was served at 12:20 PM. The resident was noted to not be eating. The resident was not cued by staff until 12:50 PM when the nurse offered to cut up his chicken. The resident was observed to eat a few bites of chicken and then left the dining room. 2. Interview with Nurse (E) after the meal service confirmed that these residents needed cueing and assistance with eating. 3. Resident #2's medical record review revealed the resident was at nutritional risk and had been readmitted to the facility following hospitalization for left femur fracture on 2/12/16. The resident's other diagnoses included: CVA (cerebral vascular accident), dementia, aortic stenosis and dysphagia. The MDS (minimum data set) assessment on 2/18/16 assessed the resident needing one person assist with eating. The resident was also seen by speech therapy on 3/25/16 for swallow dysfunction and oral function for eating. The recommendation was given for nectar thick liquids. The resident's care plan with initial date of 09/17/14 identified a problem of weight loss and decreased appetite. The goal date was continued after the resident returned from the hospital until 5/18/16. It showed approaches which included: "Pureed diet - nectar liquids, Encourage me to	F 311		

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F 311	Continued From page 30 consume more at meals, provide me with Ensure 3 x day at CN meals and Ensure Plus in between meals 4 oz 2 x day..." The facility failed to provide this resident timely assistance with eating. 4. On 4/12/16 during the noon meal, the following observations were made: Residents #26 and #27 received their meals at 12:18 PM. The chicken was observed to be stringy and residents had difficulty eating it. These two residents were not encouraged or cued to eat until 12:38 PM. 5. On 4/14/16 during the noon meal, the following observations were made: a. Resident #3 was served the peppered Swiss steak. His diet was for mechanical soft diet. His care plan was for the meat to be cut up before it was served to him. Observation at this meal evidenced that the meat was not cut up and the resident left it on the plate. This resident was also to be encourage to eat, as he was identified as having weight loss. No encouragement or cueing was observed. b. Resident #18 was observed to leave the dining room at 12:18 PM (soon after being served). The resident's chicken was not cut up and no staff re-directed her to return to the table to eat. The resident was identified as having significant weight loss. c. Residents #19 and #20 did not have their chicken cut-up. At the end of the meal, the	F 311		

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F 311	Continued From page 31 chicken remained on the plates. d. Three residents were seated at table #7. Two of the residents were served their meals. A third resident (#29), who had family visiting her, was not served her meal for at least 20 minutes after the other residents were eating. (After the surveyor prompted the staff to get the resident a tray, the resident waited about five more minutes.) The family left after the resident's meal was served. The resident ate a small amount and left. She was not re-directed to return to the table. At 12:33 PM, the Director of Nursing (DON) was asked to come to the dining room to observe that the residents' chicken was not cut up and they were not eating it. The DON requested the kitchen staff to cut the chicken up.	F 311		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to assist two of 11 sampled residents (#10 and #3) and two supplemental sample residents (#22 and #15) with appropriate and adequate meal assistance. These residents were facility assessed and was observed to be unable to perform this Activity of Daily Living (ADL),	F 312		

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F 312	Continued From page 32 requiring extensive/total assistance from staff. The findings included: On 4/12/16 during the noon meal service from 11:55 AM to 12:53 PM in the dining room, the following observations were made: 1. At Assisted table 3, two residents were being assisted by CNA (B). Resident #22 was served her meal at 12:17 PM. CNA (B), while standing next to the resident's chair, gave the resident her first bite of food at 12:22 PM. At 12:35 PM, the resident coughed and began spitting up food. The resident's clothing protector was held up in front of her face while the CNA continued to try to feed her. The same CNA was assisting a second resident who was given sporadic bites of food while assisting resident #22. 2. At Assisted table 2, two residents were being assisted by a CNA. Resident #15 was served at 12:18 PM. She choked. Resident #10 was served and being assisted with her meal when she coughed and choked. The nurse (A) was present and said that the resident sneezed. The resident was observed spitting up mucous. The CNA attempted to give the resident another drink. The resident coughed, choked, and spit up more mucous. The CNA held the clothing protector up in front of her face and attempted to give her a couple of more drinks before stopping trying to feed her. Four or five residents were seated at each of these Assisted tables. The residents needed extensive assistance and/or cueing and encouragement. When only one CNA was present at the table, the residents did not receive timely assistance.	F 312	F312- Dining room seating has been rearranged to better provide assistance from staff to residents 3,10,15, and 22. On 5/10/16 staff was educated on providing the appropriate level of assistance for residents at meals depending on the resident's individual needs that require extensive or total assistance during meals. A monitoring tool has been implemented for the dining room to ensure that residents are receiving the appropriate and timely assistance with meals. Administrator or designee will conduct audits of the dining room using the monitoring tool daily times two weeks until compliance is maintained and then weekly thereafter for two months and monthly thereafter. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	5/26/16

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F 325 F 325 SS=G	Continued From page 33 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that four of 11 sampled residents (#3, #10, #6, and #7) and one supplemental resident (#18) were assessed and provided timely and adequate nutrition to maintain normal nutritional parameters. The facility identified these five residents with significant weight loss. One resident (#10) was identified as having skin breakdown without evidence of nutritional interventions. The findings included: There was documentation to show that residents with were at nutritional risk were addressed during the care plan conferences which were tied to the residents' Minimum Data Set (MDS) assessments. Review of the notes from the care plan conferences evidenced that when nutritional problems were identified, the interventions were not timely and/or were not evaluated for their effectiveness. The amount of the ordered	F 325 F 325	F325- Physician reviewed resident #7 and #10 on 5/6/16 and felt comfort care is appropriate and anticipates continued weight loss. Resident #7 has since passed away. Resident #3 has maintained a stable weight over the last 30 days. Resident #6 has maintained a stable weight over the last 60 days. Resident #18 has maintained a stable weight over the last 30 days. Nutritional assessments will be completed by the registered dietician on all significant weight losses to include medication review, protein, skin break down, and calorie requirements by 5/18/16. All current significant weights loss will be reviewed for effectiveness of current weight loss interventions by the registered dietician by 5/18/16. Dietary Manager or designee will review all resident meal intakes with an auditing tool weekly to ensure any resident that is at risk for weight loss is identified. Dietary Manager or designee will review nutritional assessment with an auditing tool on all residents bi-monthly to ensure nutritional risks are being	5/26/16

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F 325	Continued From page 34 supplements consumed by residents, such as Ensure or Ensure Plus, was not documented. 1. Record review for resident #3 revealed the resident had diagnoses that included Parkinson's disease, hypertension, major depression disorder, and multiple fractures of the ribs. The resident was assessed on his 3/24/16 significant change and 1/15/16 quarterly Minimum Data Set (MDS) assessments to be independent with eating with set up help only and to have lost weight and had a mechanically altered diet added. a. Review of the resident's "Weight Change History" evidenced the following weights (in pounds): 10/18/15 - 147 11/21/15 - 139 12/13/15 - 137 1/16/16 - 132 2/15/26 - 132 3/14/16 - 141 4/10/16 - 129. b. Review of the resident's care plan conference summaries in relation to nutrition noted: 12/17/15 - "137# admit 151.7 (lbs) 71% meals, 896 fluid" and "Eating well currently at 137#. Needs to drink more." (Note: This represented a 7% weight loss in two months.) 1/21/6 - "Nutrition (skin Braden), 42.8% meals, 594 ml, wt 131 10% loss 180 days." "Appetite is down & not drinking well. He likes the Mighty Shakes has lost 10% in 180 days. Currently 131 lb. ___(resident name) told his wife he is feeling	F 325	addressed. All residents identified as a weight loss risk from resident meal intakes and nutritional assessments will be communicated with the Registered Dietician for further recommendations. Staff were educated on supplement documentation and weight loss interventions on 5/10/16. A monitoring tool has been developed to track weights and effectiveness of interventions. An electronic charting special requirement was implemented on 5/6/16 to ensure the amount of in-between meal supplements consumed is documented to allow for appropriate follow up and evaluation of effectiveness of interventions. Interventions will be modified as needed based on weekly weight review. Administrator or designee will audit the monitoring tool weekly for effectiveness. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	

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F 325	Continued From page 35 better when he does not eat. Staff will cut up his food, don't ask if he needs help with it. that embarrass him." 4/8/16 - "92% meals, 1397 ml fluids 127#, sig. wt loss 30, 180." "Reviewed nutrition & meal intake. Weight loss was due to taking off fluid. Eating better. Encourage fluids." c. Review of the resident's physician orders evidenced the following orders related to nutrition: 3/14/16 - re-admit orders - Mechanically altered diet. "3/30/16 - Nutritional supplement Ensure Plus 240 ml po (oral) between meals. TID (three times a day)." d. Review of the resident's care plan included a problem of "weight loss is mentioned in progress note". The goal with target date was "I will lose no more than 5% weight in 30 days over the next 90 day period 4/21/16". The approaches included: "...regular diet. small portion" "allow resident ample time to consume food. Provide assistance as needed (cueing, feeding assist)" "weigh_____ (resident name) weekly, Record results and report any loss to the physician during weekly rounds." "Observe and document resident nutritional intake for every meal." "1/21/16 Spouse states she always cut his food	F 325		

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F 325	Continued From page 36 for him. Cut his food before serving to him as he will deny needing help, to improve his consumption." "Promptly offer resident food alternatives when appropriate for any meal served." The care plan did not include the supplement that was ordered on 3/30/16. Nor did the care plan show any updates since 1/21/16, including the ongoing weight loss. e. Review of the Daily Assignment Sheet for this resident noted "independent with eating after setup" and "cut his food before bringing to table." There was no indication to cueing or assisting the resident. f. On 4/14/16 during the noon meal observation, the resident was served beef which was not cut up. The resident consumed none of the beef. No assistance or cueing was observed during the meal. g. Review of the resident's April, 2016 Medication Administration Record (MAR) evidenced the 3/30/16 order for 240 ml of Ensure Plus between meals three times a day. The scheduled times were 10:00 AM, 3:00 PM, and 8:00 PM. The documentation noted that out of 33 times, the Ensure was not administered 5 times. However, there was no notation to show what percentage of the supplement was actually consumed. 2. Medical record review for resident #10 evidenced that the resident had diagnoses that included Alzheimers, congestive heart failure, essential (primary) hypertension and osteoporosis. Review of the resident's 2/12/16 and 11/13/15 quarterly MDS assessments	F 325		

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F 325	Continued From page 37 revealed that the resident was assessed to need extensive assistance with eating and to have no swallowing disorder, a mechanically altered diet, and to have experienced weight loss which was not physician prescribed. a. Review of the resident's Speech Therapy (ST) SLP Evaluation and Plan of Treatment dated 1/17/16 revealed recommendations for puree consistency solids, nectar thick liquids, close supervision for oral intake, and use nosey cups. b. Review of the resident's "Weight Change History" evidenced the following weights (in pounds): 11/1/15 - 126 12/6/15 - 120 1/3/16 - 129 2/1/16 - 117 3/6/16 - 117 4/3/16 - 116 4/10/16 - 113. c. Review of the resident's 2/18/16 care plan conference summary in relation to nutrition and skin breakdown noted: "23% meal intake, 551 ml fluid intake" "skin - none on look back (sore to sacrum currently) 13 Braden" "...appetite is poor, went from 50% to 23% in this assessment. ...weight is down @117 lbs. Trying to push fluids...does have a sore that is being treated. Her diet has been changed to pureed to increase consumption..." d. Review of the resident's physician orders evidenced the following orders related to nutrition:	F 325		

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	535053	A. BUILDING _____ B. WING _____	04/15/2016

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F 325	Continued From page 38 "1/17/16 - Nectar thickened liquid; Offer effervescent; Nosey cups for all liquids." "1/27/16 - Mechanical soft diet with gravy on the side; discontinue pureed diet." "2/3/16 - Discontinue mechanical soft diet & start pureed diet again d/t pocketing food." e. Review of the resident's care plan included a problem of "history slow weight loss and the potential for nutritional decline". The goal with target date was "..weight will be maintained +/- 5 lbs. 2/18/16 "...current weight is 117#. She has a normal BMI of 19.5. I will not weigh less than 111# through the next review period. 5/18/16". The approaches included: "Provide me with assistance to eat at meals." "Ensure Plus 120 ml 2 x day in between meals." "Offer me snacks 2-3 x day." "Ensure 3 x day at meals." Monitor weight changes and report an increase or decrease of 5% in 30 days or 10%in 180 days." f. Review of the resident's care plan included a nursing diagnosis of "skin integrity, risk for impaired". The problem narrative indicated that the resident was receiving protein powder at each meal. The goal with target date was "my skin will remain intact through the next review period 5/18/16." The nutritional approaches to address skin breakdown included: "Encourage fluids to maintain skin integrity and	F 325		

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F 325	Continued From page 39 prevent dehydration." "Provide diet as ordered. Record food intake % at each meal. Report decline in intake to physician." "Offer food substitutes if resident refuses to eat." g. Review of the resident's April, 2016 Medication Administration Record (MAR) evidenced a 9/14/14 order for 120 ml of Ensure Plus between meals two times a day. The scheduled times were 10:00 AM and 3:00 PM. The documentation noted that out of 22 times, the Ensure was not administered 13 times. However, there was no notation to show what percentage of the supplement was actually consumed when the resident was given the Ensure. h. On 4/14/16 at the noon meal observation, two staff members confirmed that the amount of supplement taken by any resident was included in the fluid intake. The supplement intake was not separately documented to show the amount of supplement actually taken by a resident. i. Review of the resident's 3/13/16 thru 4/14/16 Fluid Intake Roster evidenced that supplements were not separately charted in order determine the effectiveness of this nutritional intervention. There was no evidence to show that the resident's nutritional needs were evaluated with the resident having significant weight loss and skin breakdown. Additionally, there was no evidence that the protein powder was being added at each meal or that alternate nutritional approaches had been attempted. 3. Record review for resident #18 revealed the	F 325		

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F 325	Continued From page 40 resident had diagnoses that included congestive heart failure, dementia with behavioral disturbances, fracture right foot, hypertension, hemiplegia, cerebral infarction, and type 2 diabetes. The resident was assessed on her 3/21/16 significant change MDS assessment to require extensive eating assistance and to have significant weight loss not physician prescribed to have no nutritional approaches. The resident was assessed on her 2/5/16 admission MDS assessment to be independent with eating with set up help only and to have no weight loss or nutritional approaches. a. Review of the resident's "Weight Change History" evidenced the following weights (in pounds): 1/29/16 - 170 2/6/16 - 165 3/6/16 - 136 4/3/16 - 150 4/10/16 - 146. b. Review of the resident's 2/5/16 (admission) care plan conference summary in relation to nutrition noted: "38% meals, fluid 822.5 ml, reg diet 170#" ""Not much of an eater at times foods repulse her. Likes dessert. Her favorite meal is the evening meal." c. Review of the resident's 5 day sig change care plan conference summary (no date found on the documentation) in relation to nutrition noted: "weight down 148# not eating well"	F 325		

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F 325	Continued From page 41 ""will try ensure between meals" d. Review of the resident's physician orders evidenced the following order related to nutrition: "4/6/16 - Ensure bid (twice a day) between meals." (Note: No amount of Ensure was specified in the order.) e. Review of the resident's care plan did not include a problem of weight loss or the potential for nutritional decline". The goal with target date was "I will eat at least 50% of meals served per week for the next 60 days 4/15/16." The approaches included: "If .... is not eating, check with her to rule out pain as a factor.: "Allow ... ample time to consume food. Provide encouragement as needed." "Monitor food intake at each meal and record. Report any decline to physician." "Promptly offer ... food alternatives when appropriate for any meal served." f. Review of the resident's April, 2016 Medication Administration Record (MAR) evidenced a 4/6/16 order for Ensure between meals two times a day. The scheduled times were 10:00 AM and 3:00 PM. The documentation noted that out of 16 times, the Ensure was not administered 8 times. However, there was no notation to show what percentage of the supplement was actually consumed when the resident was given the Ensure.	F 325		

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F 325	Continued From page 42 4. The DON was requested to provide a list of the seven residents who were noted on the CMS-672 form (Resident Census and Conditions of Residents) as having unplanned significant weight loss/gain. The DON was requested to provide dietary assessments for the residents she had identified as having weight loss/gain. Review of the Weight Change History forms for the seven residents revealed that two of the seven residents experienced weight gain. The five residents with weight loss were residents #6, #10, #3, #7, and #18. The Care Plan Conference documentation with the nutrition information which was provided as the nutritional assessments for these residents revealed summary statements about their meal intake, fluid intake, and the diet and/or supplements which they were to receive. These assessments did not show actual nutritional assessments of the individual residents' status and factors which affected their nutritional state, such as medication review, protein, skin breakdown, and calorie requirements. Nor was there evidence of modification of interventions when the residents continued to lose weight or developed skin breakdown. 5. On 4/14/16 at 8:50 AM in an interview with the Administrator (ADM) and the Director of Nursing (DON), the concerns about the nutritional issues related to weight loss and pressure sores were discussed. The ADM confirmed a recent awareness of the failure to have the dietary staff/dietician (RD) involved in providing appropriate, timely nutritional care to the residents. He indicated that he had not been aware that the hospital dietary staff/dietician were not providing the necessary nutritional interventions to address issues, such as weight	F 325		

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F 325	Continued From page 43 loss and skin breakdown. The ADM confirmed that the move to the new building and having their own dietary staff was expected to correct the nutritional issues and would offer better choices for residents in a nursing home.	F 325		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441- Resident #16 glucometer and eye drops bottle was cleaned and disinfected on 5/6/16. All resident's glucometers and eye drop bottle, were cleaned on 5/6/16 to minimize the potential for cross contamination and spread of infection. An updated policy and procedure was put in place on medication pass on 5/10/16 to minimize the potential cross contamination and spread of infection for resident #13 and #17 and residents throughout the facility during medication pass. Nurses were educated on 5/12/16 proper glucose monitoring techniques and medication pass techniques and infection control to minimize the potential for cross contamination and the spread of infection. All nurses will have competencies on glucose monitoring techniques and medication pass techniques by 5/17/16. Audits will be conducted by DON or designee using an	5/26/16

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F 441	Continued From page 44 (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 and staff interview, it was determined that the facility failed to ensure that staff techniques during glucose monitoring and medication passes minimized the potential for cross contamination and the spread of infections. The findings included: 1. On 4/12/16 at 11:45 AM, during a medication pass observation, nurse (E) was observed to take resident #16's glucometer and eye drops into the Rehab room, to sit them on the mat table, and then on the balance bar. Then she returned these items to the medication cart without cleaning them. The glucometer was returned to the case. The bottle of eye drops was placed back in the drawer. Next the nurse took a different bottle of eye drops into the Rehab room, sat the bottle on a counter, administered the drops, and returned the bottle back to the medication drawer. No cleaning of the bottle was observed. 2. On 4/12/16 at 12:10 PM, during a medication pass observation, nurse (E) was observed to prepare resident #13's medication. She placed the medications in a med cup and then spilled two of the medications on the top of the medication cart. The nurse was observed to pick up the medications, place them back in the cup, and administer these meds to the resident. (Note: The surface of the med cart is not considered	F 441	auditing tool of glucose monitoring techniques and medication techniques weekly times 8 weeks and monthly thereafter until compliance is maintained. All results will be taken to QA&A monthly until compliance is determined during the QA&A process and quarterly thereafter for one year for further review and analysis.	

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F 441	Continued From page 45 clean.) 3. On 4/12/16 at 5:20 PM, during a medication pass observation, nurse (F) was observed to take an Alprazolam out of resident #17's medication cassette. She commented that she had removed it from the wrong end of the holder. So she returned the medication with her bare hand to the cassette and closed it. She then took one from the other end of the holder. 4. On 4/14/16 at 8:50 AM, in an interview with the Administrator and the Director of Nursing (DON), these observations were discussed. The DON verified that correct technique was not used.	F 441		