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	495193	A. BUILDING _____ B. WING _____	C 08/03/2017

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8-1-17 through 8-3-17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 120 certified bed facility was 117 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 3 closed record reviews (Residents #22 through #24).	F 000		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) 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 staff interview, clinical record review, and facility documentation review, the facility staff failed to complete a SCSA (significant change in status assessment) within 14 days after determination of a change in status for 1	F 274	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and	8/18/17

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

Electronically Signed | 08/11/2017

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 274	Continued From page 1 Resident (Resident #6) of 24 residents in the resident sample. For Resident #6, the facility staff failed to assess the Resident for a significant change in condition on 2 different assessments, after the Resident's functional status declined. Dressing and bathing declined in the January 2017 assessment, and transferring and bed mobility declined in the April 2017 assessment. The findings included: Resident #6 was originally admitted to the facility on 9-30-16. Diagnoses included; Stroke, type 2 diabetes, depression, Vitamin D deficiency, abdominal aortic aneurysm, high cholesterol, hypertension, and anxiety. Resident #6's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 7-11-17. The Resident was coded with a Brief interview for mental status (BIMS), indicating moderate cognitive impairment. The Resident was coded as requiring extensive to total dependence on staff for all activities of daily living with the exception of eating. The Resident was also coded as frequently incontinent of bowel and bladder. All MDS assessments were reviewed from admission and compared. The changes experienced by Resident #6 between the admission baseline assessment and the two following assessments are below. The full admission assessment dated 10-7-16 revealed Resident #6 as requiring limited	F 274	federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. A significant change in status was completed for resident #6. 2. All residents with Change in condition, requiring a significant change may be a risk. 3. Regional Data Analyst and Verification Specialist or designee will educate MDSC on requirements for a significant change. 4. The MDS Staff will complete 100% audit of current residents completed within the last quarter with noted decline in functional abilities to assess need for a significant change assessment, then will complete 5 random audits weekly for 4 weeks. Then quarterly in QA/A committee. 5. Date of compliance 8/18/2017	

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assistance of one staff member for dressing, and extensive assistance for bathing.

The Next Quarterly assessment dated 1-19-17 coded Resident #6 as requiring extensive assistance for dressing, and totally dependent for bathing.

The Next Quarterly assessment dated 4-17-17 coded Resident #6 as requiring extensive assistance for transferring and bed mobility, when in the previous 1-19-17 assessment the Resident coded as limited assistance required for both of these.

Review of these documents reveals significant changes in 2 functional areas for each of the 1-19-17, and 4-17-17 assessments. This revealed an overall significant decline during the time after admission, without a significant change assessment being completed after each of the 2 opportunities during the decline.

On 8-2-17 The Director of Nursing (DON) was notified of the deficient practice, and stated she would have the MDS nurse, who was responsible for MDS documentation completion in the facility, made aware of the need for a significant change assessment.

On 8-3-17 at 9:00 a.m., the MDS coordinator stated she only compared the previous MDS to see if a significant change assessment was needed, and did not review all MDS's. She was made aware, at that time, that 2 opportunities to complete a SCSA were missed, and that it revealed a continued decline after admission. She stated she would send a correction to CMS (Centers for Medicare & Medicaid Services).

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F 274	Continued From page 3 On 8-2-17, and 8-3-17 at the end of the day debrief, the Administrator and DON (director of nursing) were notified of the findings, and no further documentation was presented by the facility.	F 274		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility	F 323	1. Deficient practice corrected,	8/18/17

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F 323	Continued From page 4 documentation review the facility staff failed to ensure a safe environment for 1 of 2 units, the South unit. On the South unit, the medication cart was left unlocked. The findings included: On 8/1/17 at 6:50 PM, during the initial tour, the medication cart was noted to be unlocked (the lock was not fully pushed in); the surveyor was able to open all the drawers of the cart, including drawers containing sharps and liquid medications and pills. LPN (licensed practical nurse) A came to the cart and stated, "I thought I locked it." She went on to state, "I don't think I pushed the drawers in." There were no residents in the vicinity of the medication cart. The facility presented a pharmacy policy, "Storage and expiration of Medications, Biologicals, Syringes and Needles." Section 3.3 read as followed: "Facility should ensure that all medications and biologicals, including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." On 8/2/17, at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.	F 323	medication carts are being locked 2. All Residents may be at risk related to open medication carts. 3. Staff development coordinator or designee will educate licensed nurses on need to lock medication carts 4. Staff development coordinator or designee will observe staff for compliance with locked medication cart 5 times a week for 3 weeks. Above process will be reviewed quarterly in QA/A Committee 5. Date of compliance 8/18/2017	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program.	F 441		8/18/17

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 441	Continued From page 6 circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed, for 1 resident (Resident #15) of the survey sample of 24 residents, to administer a blood sugar reading in a manner to prevent the spread of infection. For Resident #15, the facility staff failed to clean the glucometer after a previous use on another resident prior to utilizing it to obtain Resident #15's blood sugar level. The Findings included: Resident #15 was a 51 year old who was	F 441	1. Deficient practice corrected related to blood sugar reading devices. 2. All residents requiring use of Accucheck may be at risk. 3. Staff development coordinator or designee will educate licensed staff related to cleansing Accucheck Monitors per policy and procedure. 4. Staff development coordinator or designee will observe staff for compliance related to cleansing Accucheck monitors 5 times per week for 3 weeks. Above process will be reviewed quarterly in QA/A committee. 5. Date of compliance 8/18/2017	

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admitted to the facility on 3/30/17. Resident #15's diagnoses included Heart Failure, Diabetes Mellitus Type 2, and Hypertension.

The Minimum Data Set, which was a Quarterly Assessment, with an Assessment Reference Date of 7/7/17, coded Resident #15 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.

On 8/2/17 at 8:25 A.M. an observation was conducted of the facility medication pass. The charge nurse (Licensed Practical Nurse-LPN- C) utilized the glucometer to obtain a blood sugar level reading on a resident who was identified and put into the sample as Resident #16. LPN C stated that the level was 126 (mg/dL)milligrams/deciliter. She did not clean the glucometer prior to putting in back into the medication cart.

At 8:35 A.M. LPN C removed to glucometer from the medication cart and utilized it on Resident #20 without cleaning it first. Resident #20's blood sugar reading was 237 (mg/dL). LPN C then returned the glucometer to the medication cart without cleaning it. When asked about when the glucometer was supposed to be cleaned, LPN C stated, "We clean the glucometer at the end of each shift."

On 8/3/17 at 10:00 A.M. an interview was conducted with the Staff Development Nurse (RN A). When asked about the facility's policy regarding cleaning glucometers, she stated, "I went back and did an inservice today on glucometer cleaning. They are supposed to use germicidal wipes between each use, and allow it

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F 441	Continued From page 8 to dry per manufacturer's instructions. It's calibrated (tested) overnight with a test strip to ensure accuracy of readings." The facility submitted a copy of the glucometer's manufacturer's instructions. It read, "Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use." On 8/3/17 at 11:00 A.M. the facility Administrator (Administration A), and Director of Nursing (Administration B) were informed of the findings. No further information was received.	F 441		