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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/08/17 through 08/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 20) and three closed record reviews (Residents 21 through 23).	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure a sanitary, clean, orderly and comfortable interior for one of 23 residents in the survey sample, Resident # 6. Resident # 6's room was visibly dirty and unsanitary in condition. Resident # 6 was admitted to the facility on 03/10/13. Diagnoses for Resident # 6 included, but were not limited to: CHF (congestive heart failure), HTN (high blood pressure), arthritis, dementia, depression, anxiety and schizoaffective disorder.	F 253	Issue/Concern: F253: Housekeeping and Maintenance Service Goal/Obj.: Resident living environment will be sanitary, clean, and orderly Correction: Resident #6's room was thoroughly cleaned on 8/10/2017 with all identified areas of concern addressed. Other Potential: Audit conducted on all resident rooms using weekly cleaning checklist to identify areas needing correction with immediate action taken to comply with cleaning checklist. System Changes: 1.Housekeeping checklist used for weekly	9/29/17

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

Electronically Signed | 08/26/2017

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 253	Continued From page 1 The most recent MDS (minimum data set) was a quarterly assessment dated 05/23/17. This MDS assessed the resident as having a cognitive score of "8", indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from at least two staff for transfers, and toileting and assistance from at least one staff member for dressing and hygiene. The resident did not ambulate. On 08/09/17 at approximately 11:00 a.m., Resident # 6 was visited in her room. The resident was in bed, covered with blankets. The resident's bed side table was close to the bed with a cup of water sitting on it. The bedside table was visibly soiled with white dried matter. The bedside table did not show signs of being wiped clean or sanitized. At approximately 11:05 a.m., a CNA (certified nursing assistant) came into the room and left a large water mug with a straw on the resident's nightstand. The nightstand had dried, white splatter marks on the front (drawers). In front of the nightstand was a small, white, wooden stool that had a 'motion detector' sitting on top of it. The stool had visible dirt/debris with dried spillage on it. The resident's floor was observed with dirt/debris and dried spillage marks. A soiled paper napkin was laying at the bottom of the resident's bed. The resident's recliner was observed with some type of food crumbs in the seat.	F 253	cleaning for verification by housekeeper/team member of task completion; housekeeping manager to review, verify and authenticate checklist. 2.Weekly audit of housekeeping checklist by housekeeping manager of 2 rooms per neighborhood/house. Any trends/patterns to be reviewed by housekeeping manager with responsible housekeeper/team member. 3. Housekeeping checklist to be turned in to housekeeping manager to ensure completion. Monitoring QA/Oversight: Housekeeping manager will report quarterly to QAPI committee on trends/patterns in housekeeping checklist completion.	

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On 09/10/17 at approximately 8:15 a.m., the resident was again visited in her room. The resident was in bed, covered with blankets.

The resident's bedside table now had dried and wet spillage; the bedside table showed no signs of being wiped clean or being sanitized.

The resident's floor, nightstand, recliner and stool were all in the same condition as the previous observation. The soiled napkin at the bottom of Resident # 6's bed had been removed.

The privacy curtains (two), which separated Resident # 6 and her roommate were both visibly soiled with dirt and brownish stains.

At approximately 8:20 a.m., CNA # 1 was asked about housekeeping services. The CNA stated that they have housekeepers that clean the main areas, but clean the resident rooms daily.

At approximately 9:30 a.m., the administrator was asked for a policy and/or information regarding a cleaning schedule of resident rooms.

At approximately 9:40 a.m., the administrator presented a job description/policy of the expectations of the housekeeping staff and presented a room cleaning schedule.

According to the schedule Resident # 6's room is supposed to be 'deep cleaned' every Thursday.

The administrator was then made aware of the numerous concerns (listed above) regarding the cleanliness and unsanitary conditions in Resident # 6's room. The administrator stated that he

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F 253	Continued From page 3 would observe the resident's room. The administrator returned after observing Resident # 6's room and stated that all of the concerns presented by this surveyor were "completely validated" and stated that he (the administrator) agreed that the room was not clean. The facility's policy/job description titled, "Housekeeping Technician" documented, "...Resident Apartment/Rooms...thoroughly clean residents'...rooms...follows correct cleaning procedures for infection control and cleanliness in all phases of daily work...cleans beds weekly...cleans over-bed-table weekly and damp dust daily if needed...damp dust furniture daily if needed...damp dust all chairs, spokes, rungs, and under cushion weekly, daily if needed...keeps window drapes and cubicle curtains clean and free of stains and lint..." The administrator stated that the privacy curtains are to be changed our every 6 months or as needed. The DON (director of nursing), the administrator and ADON (assistant director of nursing) were made aware in a meeting with the survey team at approximately 11:40 a.m. and again informed of concerns regarding Resident # 6's room. No further information and/or documentation was presented prior to the exit conference on 08/10/17.	F 253		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		9/29/17

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F 279	Continued From page 4 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 279		

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F 279	Continued From page 5 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to develop a comprehensive care plan (CCP) related to personal safety for one of 23 residents in the survey sample, Resident #18. Facility staff failed to develop a CCP for Resident #18 regarding her spouse's sometimes loud, aggressive behaviors and episodes of anger during his visits with the resident. Findings included: Resident #18 was originally admitted to the facility on 09/04/15 and readmitted on 01/28 16 with diagnoses including, but not limited to: CVA (cerebrovascular accident) with Dysphagia and Hemiparesis, Depression, Glaucoma,	F 279	Issue/Concern: F279: Care Plans for Personal Safety Goals/Objectives: To develop comprehensive care plans regarding visitors who pose potential risk to resident safety/well-being through interdisciplinary approach and timely response to concerns Correction: The comprehensive care plan for resident #18 was amended to address her spouses sometimes loud, aggressive and angry behaviors. Other Potential: An audit of all resident care plans to identify those without interventions to address the potential risk to personal safety of the resident posed by family or	

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F 279	Continued From page 6 Hypertension, GERD (gastroesophageal reflux disease) and Myasthenia Gravis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/27/17. Resident #18 was assessed as moderately impaired in her cognitive status with a total cognitive score of nine out of 15. Resident #18's clinical record was reviewed on 08/09/17 at approximately 2:55 p.m. During this review progress notes were noted that included the following documentation: 06/12/17 13:25 (1:25 p.m.) - "...At this time, the family is making a huge adjustment by moving the husband in to the [facility initials] village in the [Name] bldg. [building]..." 06/19/17 18:51 (6:51 p.m.) - "Residents husband in just as resident is finishing her supper meal, took her to her room; this nurse took resident a cup of ginger ale (thickened) as she had asked for, and within just a few minutes, the husband brought the cup of ginger ale back to the kitchen area and thanked the food coordinator. [sic] Less than 5 mins later, resident's husband came out and was complaining that the room was 'too cold', Shahbaz followed the husband in and adjusted the temp. control. [sic] Immediately after that, the husband came to this nurse and was carrying the hearing aid chain and holder with only 1 hearing aid attached to it and raising his voice saying 'what do I do with this?' this nurse informed him that he really should leave the hearing aids in her ears until the Shahbaz get ready to put her to bed, continued to ask 'where is the other hearing aid?' [sic] in a loud, aggressive	F 279	other visitors will be completed. System changes: 1. Nursing team members will be educated on the use of the concern form to address and document behavior of resident family and other visitors that present a potential risk to the personal safety/well-being of the resident. 2. Concern forms will be reviewed weekly by interdisciplinary team. 3. The interdisciplinary team (IDT) will collaborate with residents, family and/or visitors as well as front-line providers, to address potential risk with appropriate interventions that honor resident choice and maintain resident safety. Monitoring/QA Oversight: IDT and QAPI agenda will include review of concern forms that led to care plan modifications for trends/patterns.	

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voice; this nurse responded by saying 'the hearing aid is on her, somewhere; please don't take then off until she is ready to go to bed'. [sic] This nurse then asked the resident, 'do you want the hearing aids on or off?' and the husband began answering and this nurse said 'I am asking her what she wants to do', [sic] resident stated, 'well, I guess I'll take them off..."

06/19/17 22:49 (10:49 p.m.) - "Resident's husband returned to this house about 20 minutes after leaving and came in and stated that he 'had lost his glasses' and he went directly into Room #[number], went to the resident's nightstand and picked up her glasses, this nurse said 'Mr [Name], are you sure that they are your glasses?' [sic] he stopped, looked at them and don't stated 'No, they are hers' and then he said to this nurse 'do you have my glasses?' I responded 'No sir I don't have your glasses...' [sic] He attempted to leave the house, but did not remember to put the # in the keypad and shook the door several times; Shahbaz reminded him about the keypad and assisted him out..."

06/22/17 17:19 (5:19 p.m.) - "...husband visits daily now that he has moved onto [initials] campus..."

07/04/17 18:05 (6:05 p.m.) - "Resident's husband came to this house just as resident was finishing her supper meal and began pulling backward on her w/c [wheelchair' several times, this nurse observed his actions and reminded him that he needs to release the brakes on the w/c before he can move it, he replies, 'oh, yeah, that's right' and released the brake, then pushed resident to her room. [sic] In just a few minutes, the husband pushing the resident in her w/c came to the

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Nurse's office and states, 'Do you know how to put a hearing aide in?' [sic] this nurse responded 'yes'; he then said 'well, here, then put this in' as he was holding the hearing aide holder strap; this nurse looked closer at the resident and stated 'the hearing aide is in her ear'; he said, 'Well, what is this?' and this nurse once again stated, 'that is her hearing aide' [sic] Resident and her husband both become very aggressive and demanding when they approach any staff member about any aspect of her care..."

07/05/17 18:51 (6:51 p.m.) - "Husband in to see this resident during supper meal and kept asking 'are you finished' - 'are you finished yet'??? [sic] After resident was finished with her supper meal, husband pushed resident to the TV room, but then he kept getting up and down and asking, 'can you put her down now?' [sic] Shahbaz attempted to explain to resident's husband several times that resident needs to sit upright for at least 30 minutes after finishing her meal in order to avoid vomiting related to GERD. [sic] The resident is not asking to be put to bed, the husband is the one who wants her to be put to bed before he leaves to go home; we have explained the situation to him numerous times. [sic] Husband now has resident sitting out in the Great Room and is pacing until the Shahbazim get her in the bed."

07/07/17 11:25 (a.m.) - "Resident's husband came in at breakfast time and stayed until resident got up. Resident came to the table to eat about 1030 [10:30 a.m.], and resident's husband paced between the sun-room, where he was watching the news, and the table. She started to cough while eating, and he hovered over her, saying she shouldn't eat anymore and

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took her plate away."

07/08/17 07:00 (a.m.) - "Resident was in her room with Shahbaz doing hs [bedtime] care, when resident's husband came into the house very hurriedly and wanted to see the resident, this nurse told him that she would be finished shortly, so he paced back and forth in the great room until the Shahbaz came out of the room. [sic] Husband entered the room and said 'Why doesn't she have any pants? What have you done with all of her pants?' Shahbaz said 'do you mean her slacks? Because she has 5 pair hanging here in the closet and I am going to wash the pair she just took off which will be ready for in the morning, so then she will have 6 pair.' [sic] Husband responded 'OK, well, I didn't think she had any pants to wear to church in the morning, so that's good, OK, see ya in the morning' [sic] Husband then left the house and was much calmer when he left."

07/08/17 15:15 (3:15 p.m.) - "Today after lunch resident's husband started pushing resident from the table to take her to her room. When moving her the O2 [oxygen] tubing of another resident became tangled in the wheelchair of Mrs. [Name]. Mr. [Name] was politely asked to wait for staff to help. He became angry and yelled at staff he was taking his wife to her room. We attempted to explain to him about the O2 tubing but he continued to be angry. We were able to show him the problem and he then stopped yelling and allowed staff to untangle the tubing. No injuries to anyone occurred."

07/12/17 18:28 (6:28 p.m.) - "...Resident's husband now lives on campus and visits frequently and he can also get her very

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agitated..."

07/16/17 18:32 (6:32 p.m.) - "Resident's husband [Name] in to visit resident - noted immediately to go out on porch and move resident's WC back in the home-Staff approached resident and asked husband to allow resident to remain on porch until she is ready to go to bed. [sic] Husband became immediately angry; raised his voice; speaking loud and intimidating;behaving in a threatening manner with staff; and attempted to state 'This is my wife, I can do what I want!' [sic] Second nurse, then stepped in to the conversation and asked resident if she wants to remain outside. Resident states 'Yes.' Resident was returned to porch and husband accompanied. Staff spoke with resident regarding his behaviors in the home."

07/27/17 08:16 (a.m.) - "Resident's husband came into the house, went immediately to the couch, took a blanket off of the back, and took it into resident's room. He then proceeded to go into another resident's room, take a blanket, and on his way into resident's room, this nurse explained that the blanket belonged to another resident, and returned it to that resident's room. [sic] The other resident's family had previously complained this week that her blanket had gone missing, and was found in this resident's room."

08/06/17 14:53 (2:53 p.m.) - "At 1415 [2:15 p.m.] resident's husband came back into the house, 6-2 nurse informed him that she was in bed napping and asked him to wait for a while before waking her because on Sat. she did not get to lay down for a rest due to visiting with family; he agreed and asked 'how long should I wait', this nurse responded, 'at least 30 mins'. [sic] This nurse

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went next door to [Name] and completed the shift change and when we returned, we found that the resident's husband had gone in her room and shut the door..."

08/07/17 18:12 (6:12 p.m.) - "Resident continues to become agitated and very angry when she is confused - husband now lives on campus and is in/out of the house several times thru the day..." [sic]

08/08/17 18:10 (6:10 p.m.) - "At approx 1800 [6:00 p.m.] resident's husband entered the home and walked directly over to where resident was sitting at the dining table and attempted to remove her plate, stating 'You have had enough to eat.' Nurse intervened and asked husband to allow resident to decide when she had finished. At this time, resident states 'I am done.' [sic] Husband then removed resident from table via wheelchair and took her to her room; when attempting to move WC thru doorway, resident was heard yelling at husband for striking her feet on the door frame." [sic]

Subsequent review of Resident #18's CCP did not reveal any approaches or interventions regarding Resident #18's personal safety when husband is being overly aggressive, loud or angry.

The Administrator, DON (director of nursing) and ADON (assistant director of nursing) were informed of the above documentation during a meeting with the survey team on 08/09/17 at approximately 4:00 p.m. The ADON stated, "We are aware of his behaviors and are working with him and the family. I believe we have addressed this in her care plan. Let me look into that and

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F 279	Continued From page 12 get back with you. He definitely dictates the mood of the house." During a meeting with the survey team on 08/10/17 at 11:40 a.m. the Administrator, DON and ADON agreed there was nothing included in the care plan to address Resident #18's spouse's behaviors and outbursts. The ADON stated, "We will have to develop a behavior contract with him and call a special meeting with the family to discuss this." No further information was received by the survey team prior to the exit conference on 08/10/17.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		9/29/17

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right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

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F 280	Continued From page 14 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 23 residents in the survey sample, Resident # 9 regarding falls. Resident # 9 had a history of falls, with continued attempts to get up and/or ambulate without assistance. The resident's CCP was not updated with the resident's fall and/or interventions related to the falls. Findings include: Resident # 9 was admitted to the facility on 08/15/16, with the most current readmission on 01/30/17. Diagnoses for Resident # 9 included, but were not limited to: anemia, osteoporosis, history of a stroke, dementia, malnutrition, anxiety disorder and depression.	F 280	Issue/Concern: F280-Comprehensive Care Plan (CCP)requires information to reflect reviews/revisions associated with post fall interventions Goal/Obj: Process change will be that all medical/non-medical interventions will be indicated in the comprehensive care plan Correction: Resident #9 fall documentation will be verified and completed in the care plan Other Potential: Audit review of care plans for residents with 2 or more falls to ensure care plans have documented interventions System Changes: Review/revisions of incident investigation post-fall process will be revised to include use of 5 Whys Root Cause Analysis to ensure prompt and appropriate	

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F 280	Continued From page 15 The most current full MDS (minimum data set) assessment was dated 02/06/17, which assessed the resident as having short and long term memory impairment and as having severe impairment in daily decision making skills. The resident was also assessed as requiring assistance from at least one staff members for most ADL's (activities of daily living). The resident also triggered in the CAAS (care area assessment summary area) for falls on this MDS. During clinical record review on 08/09/17, Resident # 9's nursing notes were reviewed and revealed that the resident had approximately 9 falls from December 2016 through January 2017. The resident's CCP was reviewed and documented that anti roll back brakes were implemented on the resident's w/c (wheelchair) on 01/02/17, but did not have any of the falls listed during the above time frame and did not address any other interventions put in place for Resident # 9. On 08/09/17 at approximately 4:00 p.m., the DON (director of nursing), administrator and the ADON (assistant director of nursing) were made aware of concerns regarding Resident # 9 numerous falls and that the resident's CCP had not been updated to reflect the falls and/or any new interventions to address the continued falls. The DON stated that they (facility) would see what they could find. On 08/10/17 at approximately 9:45 a.m., the DON (director of nursing) and the ADON (assistant director of nursing) presented information regarding Resident # 9's interventions and/or care during this time. The ADON stated that the	F 280	interventions are in the care plan. Medical Interventions associated with a fall will be identified as part of the fall care plan such as Treatments for UTI's, bowel program changes and alterations in sleep/wake cycle, etc. Monitoring/QA Oversight: Audit of any residents with 2 or more falls within 7 days to ensure each fall and intervention is documented, resident centered and updated on the care plan. Audit completed weekly x4, then every other week x4, then monthly	

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F 280	Continued From page 16 resident had a urinary tract infection and it was felt that caused the resident confusion and increased falls, the ADON stated that they assessed and treated the resident. The ADON also stated that the resident that family was involved with care and that a therapy screen had been ordered for the resident, and that the resident's bowel regimen had been changed during this time. The DON and ADON were made aware that the resident's CCP is where the resident's care is directed from and that the above information should be reflected in the resident's CCP. The DON and ADON agreed, but could not explain why the resident's CCP was not reviewed and/or revised regarding the resident's falls. No further information and/or documentation was presented prior to the exit conference on 08/10/17.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 309		9/29/17

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F 309	Continued From page 17 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, and staff interview, the facility staff failed to follow physician's orders for one of 23 residents in the survey sample, Resident # 16. Resident # 16 was admitted to the facility on 08/05/17. Diagnoses for Resident # 16 included, but were not limited to: depression, high blood pressure, acute cystitis (bladder infection), and fall at home resulting in a right ankle fracture. The resident did not have any completed MDS information available . The resident's admission assessment, assessed the resident as being A&O X 4 (alert and oriented	F 309	Issue/Concern: F309-Facility staff failed to follow physician order of "check capillary refill of effected extremities 2 times per day." The order was not followed related to nail beds covered by dark nail polish preventing staff from conducting proper assessment. Goals/Objectives: 100% of physician orders stating to check capillary refill will be completed by removing any barriers to conduct assessment. Correction: Toenail polish removed from resident #16 upon discovery of identified toenail polish	

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F 309	Continued From page 18 times 4). The resident's clinical record was reviewed and documented that the resident lived at home and had a syncope episode, which resulted in a fall and fracture of the right ankle; the resident was admitted to the facility for rehab. Resident # 16's current physician's orders were reviewed and included an order for, but not limited to: "...check capillary refill of affected extremities (sic) 2 times per day during Day, Evening, ..." This order date was 08/05/17 and the start date of the order was 08/05/17. On 08/10/17 at approximately 8:40 a.m., the resident was visited in her room. The resident was dressed, sitting on the side of her bed. The resident was observed with an ace type wrap/bandage on her right foot (toes exposed) extending up her ankle and on to about mid calf. The resident's right toes were exposed and were observed with dark pink nail polish on all five toes. The resident had a non-skid sock on the left foot. The resident interviewed and ask about the reason for admission. The resident stated that she had been at home and felt kind of sick to her stomach and then felt dizzy and the next thing she knew she had passed out and as a result she ended up with the fractured ankle. The resident was asked if the staff are checking the foot. The resident stated yes, and further stated that they (staff) check the pulse by feeling under the dressing. The resident was asked if the staff check a capillary refill [The capillary refill is a quick test done on the nail beds, it is used to	F 309	inhibiting assessment. Other Potential: 100% Audit conducted on resident's with order for capillary refill assessments to ensure no barriers to assessment were present and all nail beds were visible. System Changes: Staff education to be provided regarding proper technique of capillary refill assessment. Monitoring/QA Oversight: 100% Audit of capillary refill orders to verify absence of barriers to assessment completion will be conducted weekly for one month; then 100% of capillary refill order for 3 months. Any trends/patterns will be reported to QAPI for review and action as needed.	

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monitor the amount of blood flow to tissue, which cannot be seen in the presence of nail polish covering the nail bed]. The resident stated that she did not know what that was.

The resident was asked how long her nail polish had been on her toes. The resident stated that it had been on since before she fell. The resident stated that she was supposed to take a trip to California and she and her daughter had got pedicures preparation and then she had the fall.

The process of checking capillary refill was explained to the resident. The resident stated, "Good, maybe they will take the polish off of both my feet."

During the clinical record review on 08/101/17, Resident # 16's nursing notes were reviewed.

A nursing note dated 08/06/17 documented, "...circulation assessed and found intact with brisk capillary refill and normo-thermic [normal body temperature] to touch..."

A nursing note dated 08/08/17 documented, "...capillary refill and pedal pulse obtained..."

On 08/10/17 at approximately 11:50 a.m., the administrator, DON and ADON were made aware of the above information. The DON was asked what was the expectation for checking a capillary refill on someone like Resident # 16. The DON stated that, that is the only way I know how to do it, is on the nail. The DON confirmed that it should also be done on the affected extremity.

No further information and/or documentation was presented prior to the exit conference on

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F 309	Continued From page 20 08/10/17.	F 309		