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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 5/13/19 through 5/14/19. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 253 certified bed facility was 227 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents 1 through 7).	F 000		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of one of 7 residents in the survey sample (Resident #1). The findings included: The facility staff failed to provide or offer psychosocial services after an allegation of sexual abuse involving Resident #1 and a staff member or document the social services interviews with Resident #1 on two different occasions after the alleged incident on 5/3/19.	F 745	F745 Corrective Action(s): While Resident #1 had been interviewed and discussed the incident with Social Services, this discussion and a proper psychosocial assessment had not been completed. A psychosocial assessment was completed by Social Services on Resident #1 on May 21, 2019. No new issues or concerns were present based upon this assessment. Identification of Deficient Practices & Corrective Action(s): All other residents who have had abuse	6/28/19

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

Electronically Signed | 06/11/2019

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F 745	Continued From page 1 The complaint read that on 5/3/19, Resident #1 reported that during bedtime on 5/2/19, a male C.N.A. (certified nursing assistant) was assisting her to get ready for bed. As she was undressing, the C.N.A. was standing too close to her and was aroused. Resident #1 told him to back up. A few minutes later, she was attempting to take her bra off when the same C.N.A. touched her breasts inappropriately She told him, "You could lose your job for things like that" and he replied "please don't tell on me." Throughout the investigation, Resident #1 has been very detailed and consistent with the details of the alleged incident. The C.N.A. was terminated. Resident #1 was admitted to the facility on 12/3/18 with diagnoses that included but not limited to hereditary lymphedema, dysphagia, unspecified dementia without behavioral disturbances, muscle weakness, difficulty in walking, cognitive communication deficit, localized edema, polyneuropathy, hypothyroidism, type 2 diabetes mellitus, dysthymic disorder, anxiety, dry eye syndrome, rheumatic mitral stenosis, chronic diastolic heart failure, varicose veins, allergic rhinitis, chronic obstructive pulmonary disease, constipation, and gastroesophageal reflux disease. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/8/19 assessed the resident with a BIMS (brief interview for mental status) as 9/15. There were no signs of delirium, psychosis, or behaviors that affected others. Resident #1 was assessed to require extensive assistance of one person for dressing and toilet use. Resident #1's comprehensive care plan identified	F 745	and/or neglect allegations may be at risk of not having properly received a psychosocial assessment after the alleged incident. A review of all abuse & neglect allegations for the past 90 days has been completed to audit for the presence of a proper psychosocial assessment following the alleged incident. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident form will be completed for each incident identified. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The Social Services department has been in-serviced by the Administrator on the need to properly complete a psychosocial assessment on a resident after an allegation of abuse and/or neglect. Monitoring: The Administrator is responsible for compliance. The Administrator and/or designee will complete a weekly audit of resident abuse/neglect allegations to ensure that a psychosocial assessment has been properly completed for each resident after each alleged incident. Detail findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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that the reason had potential for depression, anxiety, stress r/t (related to) need for facility placement. Interventions: Arrange for psych (psychiatric) consult, follow up as indicated, discuss with me/family/caregivers any concerns, fears, issues regarding health, encourage and provide opportunities for exercise, physical activity.

Resident #1's current comprehensive care plan identified the resident has a diagnosis of depression and is on antidepressant medication. Interventions: Give medication ordered by physician. Monitor /document side effects and effectiveness. Monitor/document/report to MD (medical doctor) prn (as needed) ongoing s/sx (signs/symptoms) of depression unaltered by antidepressant medication: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance, provide/encourage/support participation in daily facility life, psych consults per order.

Resident #1's care plan identified that the resident may have impaired thought processes r/t (related to) her dx (diagnosis) of dementia. Interventions: Communicate with me regarding capabilities and needs. Notify when changes in condition are identified.

A review of Resident #1's clinical record did not reveal a psychosocial assessment had been completed by the social worker after the alleged

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incident on 5/3/19.

The surveyor interviewed the social worker on 5/13/19 at 11:43 a.m. The social worker stated she talked to the resident. Resident #1 explained what happened. The SW stated she wrote everything down, then typed the statement up, had Resident #1 read the statement and sign it. The SW stated she gave the statement to the director of nursing. The SW stated she and the unit manager were given 2 photos of male C.N.A.s that worked on 5/2/19 to Resident #1 to view and choose the person she saw. Resident #1 picked a photo and gave the one she chose to the DON. The surveyor asked if the social worker had documented her discussion with Resident #1 in the clinical record and she stated no or offered counseling. The social worker stated there had been no reports of sexual abuse by the staff or residents. She stated there were no further concerns. She stated Resident #1 didn't want to report the incident.

The surveyor met with the social worker and the director of nursing again on 5/14/19 at 10:30 a.m. The social worker stated she chatted with both Resident #1 and Resident #2 the next day and neither one had any issues. The social worker was asked if any other residents under the care of C.N.A. #1 were interviewed and the social worker stated none were. The social worker stated she had heard no concerns from any other residents. The social worker asked if her interview/assessment with Resident #1 was documented and the social worker stated no.

The Social Services Mini Assessment was completed 12/14/18. Comments read, "She noted feeling more down/depressed due to

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F 745	Continued From page 4 change in environment. Counseling services offered and declined at this time. No behavioral concerns." The social worker did not complete a social service assessment after the allegation of sexual abuse on 5/3/19 or document her assessments of Resident #1 in the clinical record. The clinical record did have a targeted behavior observation summary completed by the nursing staff on 5/3/19, 5/6/19, and 5/7/19. No evidence of behaviors or psychosis. The summaries did not address mood. The administrator, the director of nursing, and the assistant director of nursing were made aware of the issue with the lack of social work assessment and documentation of the alleged sexual abuse in the end of the day meeting on 5/14/19. No further information was provided prior to the exit conference on 5/14/19.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		6/28/19

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F 761	Continued From page 5 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to store physician ordered medications in a locked and secured area for 2 of 7 residents (Resident #6 and Resident #7). The findings included: 1. The facility staff failed to ensure physician ordered medications were in a secured area for Resident #6. Insulin and cough drops were left attended by the nurse on the unit. Resident #6 was admitted to the facility initially 1/28/14 and readmitted 4/30/19 with diagnoses that included but not limited to sepsis due to Escherichia coli, type 2 diabetes mellitus, chronic diastolic heart failure, chronic respiratory failure with hypoxia, dysphagia, unsteadiness on feet, and urinary tract infection. Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 5/7/19 assessed the resident with a BIMS (brief	F 761	F761 Corrective Action(s): Resident #6□s Humalog Kwik Pen has been discarded with a new pen obtained per physician orders. The Halls cough drop lozenges were appropriately stored. Resident #7□s Novolog Flex Pen has been discarded with a new pen obtained per physician orders. Identification of Deficient Practices & Corrective Action(s): All other Medications may have potentially been affected. The DON and/or designee will conduct a 100% review of all medication carts and medication rooms to identify any existing mislabeled, expired or discontinued medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident form will be completed for each incident identified.	

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F 761	Continued From page 6 interview for mental status) as 15/15. Resident #6 had no indicators of delirium, behaviors or psychosis. During the survey, the surveyor entered the facility on 5/13/19 at 10:35 p.m. and going to the mid-west unit. Upon arrival to the unit at 10:37 p.m., the surveyor observed one certified nursing assistant (6) sitting at the nurse's station eating potato chips. The surveyor observed a Ziploc bag with 2 different medications in one package and an individual insulin pen lying on the counter. The surveyor asked C.N.A. #6 where the nurse was and the C.N.A. stated the nurse stepped off the unit. C.N.A. #6 finished her chips and left the nurses station, leaving the medications unattended. The packet containing medication for Resident #6 included Humalog Kwik Pen dispensed 5/13/19 and lozenges with directions that read to dissolve one lozenge in mouth q3h (every 3 hours) while awake as needed-18 loz (lozenges) dispensed on 5/13/19. The nurse (licensed practical nurse #6) returned to the unit at 10:57 p.m. L.P.N. #6 was informed of the surveyor's observation on 5/13/19 and stated she didn't know the medications were here. L.P.N. #6 stated the pharmacy closes at 8:00 p.m. and stated usually they put the medication in the cart. L.P.N. #6 stated she had not been at the desk for a while and didn't know they were there. The surveyor reviewed Resident #6's May 2019 physician's orders. Resident #6 had orders for Humalog Solution 100 unit/ml (milliliter) Inject per sliding scale before meals and at bedtime for	F 761	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The licensed nursing staff will be in-serviced by the pharmacy consultant and/or DON on the policy for monitoring medications to ensure proper labeling, dating and removal of all expired or discontinued medications and supplies from the medication carts and medication room. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform weekly audits of all medication rooms and medication carts to ensure that medications are being labeled and dated appropriately and that all expired or discontinued medications are being removed per protocol. Detail findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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diabetes and orders for Hall's cough drops lozenge 7.6 mg (milligrams) give 1 lozenge by mouth q every 4 hours as needed for sore throat sugar free if possible. The most recent order for the lozenge was not provided to the surveyor.

The surveyor interviewed the pharmacy technician on 5/14/19 at 8:55 a.m. The pharmacy technician stated the pharmacy staff do not leave medications unattended and stated the nursing staff have to sign for medications.

The surveyor informed the director of nursing (DON) of the above concern on 5/14/19 at 10:30 a.m. and requested the facility policy for the storage of medications. The DON stated the nurses have to sign for narcotics only.

The director of nursing provided the surveyor with the facility policy titled "Medication Refill Policy" dated 4/10/19. The policy read in part, "Unit dose refills are placed in the individual med drawer by the pharmacy tech."

No further information was provided prior to the exit conference on 5/14/19.

2. The facility staff failed to ensure physician ordered medications were secured in a locked area for Resident #7.

Resident #7 was admitted to the facility initially 5/31/2011 and readmitted 10/7/17 with diagnoses that included but not limited to type 2 diabetes mellitus, schizoaffective disorder, difficulty in walking, cognitive communication deficit, abnormal posture, dysphagia, insomnia, atrial flutter, constipation, and chronic kidney disease.

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Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/16/19 assessed the resident with a BIMS (brief interview for mental status) as 9/15. Resident #7 had no signs or symptoms of delirium, behaviors that affected others or any signs or symptoms of psychosis.

During the survey, the surveyor entered the facility on 5/13/19 at 10:35 p.m. and going to the mid-west unit. Upon arrival to the unit at 10:37 p.m., the surveyor observed one certified nursing assistant (6) sitting at the nurse's station eating potato chips. The surveyor observed a Ziploc bag with 2 different medications in one package and an individual insulin pen lying on the counter. The surveyor asked C.N.A. #6 where the nurse was and the C.N.A. stated the nurse stepped off the unit. C.N.A. #6 finished her chips and left the nurses station, leaving the medications unattended.

The individual insulin pen was for Resident #7 and read Novolog flex pen prefilled syringe-dispensed 4/29/19 and opened 5/7/19.

A review of the May 2019 physician's orders included an order for Novolog Flex Pen Solution Pen-injector 100 units/ml Inject 46 units subcutaneously one time a day for IDDM (insulin dependent diabetes mellitus) Give with dinner and Inject 16 units subcutaneously one time a day for IDDM Give with breakfast and Inject 18 units subcutaneously one time a day for IDDM Give with lunch.

The nurse (licensed practical nurse #6) returned to the unit at 10:57 p.m. L.P.N. #6 was informed of the surveyor's observation on 5/13/19 and

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stated she didn't know the medications were here. L.P.N. #6 stated the pharmacy closes at 8:00 p.m. and stated usually they put the medication in the cart. L.P.N. #6 stated she had not been at the desk for a while and didn't know they were there.

The surveyor interviewed the pharmacy technician on 5/14/19 at 8:55 a.m. The pharmacy technician stated the pharmacy staff do not leave medications unattended and stated the nursing staff have to sign for medications.

The surveyor informed the director of nursing (DON) of the above concern on 5/14/19 at 10:30 a.m. and requested the facility policy for the storage of medications. The DON stated the nurses only sign for narcotics.

The director of nursing provided the surveyor with the facility policy titled "Medication Refill Policy" dated 4/10/19. The policy read in part, "Unit dose refills are placed in the individual med drawer by the pharmacy tech."

No further information was provided prior to the exit conference on 5/14/19.