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F 000	INITIAL COMMENTS Surveyor: 27973 This was a recertification survey conducted at Mayville Nursing and Rehab Center from 9/10/12 to 9/12/12. This is a special focus facility. Census: 71 Sample Size: 15 Supplemental Sample Size: 6 Number of Citations: 12 The most severe citation was F441 with a severity and scope of no actual harm/more than minimal potential, patterned. Survey Coordinator: 27973	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care	F 164		

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

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institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Surveyor: 30992

Based on interview and record review, for 1 out of 13 residents reviewed, the facility failed to ensure confidentiality of resident personal and clinical records.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

A resident's vital signs were observed on top of an unattended medication cart in the hallway near the dining room.

As evidenced by:

The facility policy titled "Confidentiality of Protected Health Information" dated October 1999 and revised December 2001 and January 2005, indicates the following:

Center personnel will use the resident protected

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health information only within the contest of their professional responsibility.

People who come to the center as residents and are admitted, entrust very intimate and personal data to the staff at various levels in the organization. Because of the sensitivity of this information and the consequences of its indiscriminate use, staff are obligated to protect the resident through an appropriate use of the information.

1. Do not discuss the information gained from resident interviews or resident records with anyone outside of the center (friend or family member, etc.) nor with other employees who have no need of the information in order to carry out their responsibilities.
2. Assure the resident lists are distributed judiciously and those work units receiving such are responsible for the discriminate use and availability.
3. Refer to the HIPAA Policy and Procedure Manual for information.

On 9/11/12 at 8:25 AM, Surveyor 30992 observed vitals for a resident written on a paper towel, placed upright on the medication cart on Deer Path Hall outside of room 113. The information contained the resident's first name, room number and vitals taken that morning and was in view of anybody walking down the hallway.

On 9/12/12 at 10:14 AM, Surveyor 30992 interviewed RN U regarding the vitals on the medication cart. RN U stated she did not realize the vitals were upright and visible on the medication cart. RN U stated it is not acceptable

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F 164	Continued From page 3 to leave confidential medical information in a location where it is visible. On 9/12/12 at 2:29 PM, Surveyor 30992 interviewed DON (Director of Nursing) B who confirmed the vitals should not have been left in view on the medication cart.	F 164		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 27973 Based on observation and interview, the facility did not ensure that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care and make choices about aspects of his or her life in the facility that are significant to the resident for 1 of 15 sampled residents and 3 of 6 supplemental residents reviewed (Residents 4, 17, 18 and 16). Resident 4 stated that she does not like her seatbelt and that she has to wear it because she does not follow orders at the facility. Resident 4 stated that it was not a choice for her to wear the seatbelt and that she hates it.	F 242		

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F 242	Continued From page 4 During the group interview, Resident 17 and Resident 18 stated that they do not get what they order for meals. During the initial tour of the facility, Resident 16 stated that he does not get what he orders for meals. This is evidenced by the following: Example 1 Resident 4's medical record contains a document titled "Safety Device Information" dated 5/2/12. This document is not signed by Resident 4. Resident 4 is her own decision-maker. The facility completed a Minimum Data Set (MDS) assessment dated 6/29/12 on Resident 4. This assessment indicates that Resident 4 scored 12 points in the Brief Interview for Mental Status (BIMS). A score of 12 points indicates that Resident 4 is cognitively intact. Resident 4's Safety Device Data Collection, dated 7/10/12 (Quarterly Assessment) states, "Safety Device Reduction Warranted? No (checked). If no, why does current safety device continue to meet resident's needs? Reduces resident from getting up by self." The facility did not have evidence that they discussed the use of the seatbelt with Resident 4 or give Resident 4 the choice of use or discontinuation of the seatbelt. Resident 4's "Progress Notes" do not indicate that the facility discussed the use of the seatbelt with Resident 4.	F 242		

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Resident 4's "Safety Device Plan of Care" dated 7/12 states, "SRSB (self releasing seat belt) when in w/c (wheelchair)..."

Surveyor 27973 spoke with Resident 4 on 9/10/12 at 2:05 PM. Surveyor 27973 asked Resident 4 about the seatbelt she was wearing. Resident 4 stated that she does not like the seatbelt and that she has to wear it because she does not follow orders. Resident 4 stated that she was too impatient. Surveyor 27973 asked Resident 4 if she told anyone at the facility about her dislike of the seatbelt. Resident 4 stated that she told someone about a month ago about it.

Surveyor 27973 again spoke with Resident 4 about the seatbelt on 9/12/12 at 4:45 PM. Resident 4 stated that the facility just put the seatbelt on her and that she did not have the choice to wear or not wear the seatbelt. Resident 4 stated that she hates the seatbelt.

Surveyor 27973 spoke with Director of Nursing (DON) B on 9/12/12 at approximately 2:30 PM. DON B stated that the process for applying safety devices includes identifying a need for a device, and what the device is needed for, for example for positioning or an emergency. DON B stated that the facility would then call the doctor and that the facility would also get therapy involved. Surveyor 27973 asked DON B if the facility would include the resident in this decision. DON B stated that the resident would be involved in the decision. DON B stated that she would expect her staff to talk to the resident related to applying the device. Surveyor 27973 asked DON B if the facility gave Resident 4 an option to wear or not wear the seatbelt. DON B sated that she knows

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that Resident 4 has been agreeable to the seatbelt. Surveyor 27973 requested evidence that the facility spoke with Resident 4 about the seatbelt upon application and at the quarterly review. DON B stated she would look into it.

No additional information was provided.

Example 2
During the resident Group Interview on 9/11/12 at 10:30 AM, Residents were asked about food served at the facility. Resident 17 stated that the night before he ordered a soft taco. He stated that he did not get the soft taco. Resident 17 stated, "Here, if you order, you don't always get it. It happens too often. It happens a lot." Resident 18 stated that sometimes they don't have what the menu says and they just give you whatever.

During the initial tour on 9/10/12 at 9:00 AM, Surveyor spoke with Resident 16. Surveyor 27973 asked how things were going at the facility. Resident 16 stated that Surveyor 27973 could start in the kitchen. Resident 16 stated that the residents have choices about what they eat, but you don't get that food item that you choose. Resident 16 stated that he circles items on his menu, but does not get that item. Resident 16 stated that he tells the facility staff but it does not do any good.

Surveyor 27973 spoke with Dietary Manager (DM) D on 9/12/12 at 2:05 PM. DM D stated that the menus are run from the corporation and the cooks have to follow the menus. Surveyor 27973 indicated that she noticed there was coffee cake/Danish served this morning at breakfast, but not a donut, per some resident's meal cards. DM

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F 242	Continued From page 7 D stated that she had the coffee cake in the freezer and that they are both a sweet. DM D stated that the meal card menus that are given to the residents to fill out are not changed because they are already printed up. DM D stated that she lets all of the residents know when there is a change in the menu item. Surveyor 27973 informed DM D about the concerns voiced by residents about their meal choices and not getting what they choose.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 29094 Based on observation, interview and record review, the facility did not provide services in accordance with each resident's plan of care for 3 of 13 residents reviewed (Residents 8, 9, and 11.) Resident 8 had a physician order for Double layer Tubigrips. Resident 8 was observed not wearing Tubigrips to his lower legs on 2 days of the 3 day recertification survey. The facility did not follow Resident 8's plan of care. Resident 8's care plan states Resident 8 is to put legs on 2 pillows when in recliner chair and has legs up. Observations were made on 2 days of the 3 day recertification survey where this	F 282		

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intervention was not in place.

Resident 9's care plan states Resident 9 is to wear a palm protector in her right hand. Observations were made on 2 days of the 3 day recertification survey when this care plan intervention was not followed.

Resident 9's care plan states Resident 9 is to have a pommel cushion in her Broda chair. Observations were made on 3 days of the 3 day recertification survey when this care plan intervention was not followed.

Resident 9's care plan states Resident 9 is to be checked and changed every 2 hours. Observations were made when this care plan intervention was not followed.

This is evidence by:

On 9/12/12, at 4:25 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding following Residents' care plans. DON B stated she would expect all care plans and Physician orders to be followed as written.

Example 1 (Occurrence 1)
Resident 8 was admitted to the facility on 2/15/05 with the following diagnoses; Transient Arterial Occlusion, Peripheral Vascular Disease, Coronary Artery Disease, Syncope...

Resident 2's Physician order sheet, dated 9/12 is documented Double Layer Tubigrips from base of toes to knees.

On 9/10/12, at 10:45 AM Surveyor 29094

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observed Resident 8 sitting in his recliner chair in his room. Resident 8 was observed with white stockings on both legs. Resident 8 was not wearing a double layer of Tubigrips according to his Physician order.

On 9/10/12, at 1:15 PM Surveyor 29094 observed Resident 8 sitting in his recliner chair in his room. Resident 8 was observed with white stockings on both legs. Resident 8 was not wearing a double layer of Tubigrips according to his Physician order.

On 9/11/12, at 10:35 AM Surveyor 29094 observed certified Nursing Assistant (CNA) I transfer Resident 8 to the toilet. CNA I removed Resident 8's pants exposing Resident 8's lower legs. Resident 8 had 1 pair of white knee high stocking on his bilateral lower legs. Resident 8's did not have double layer of Tubigrips on his bilateral lower legs.

On 9/12/12 at 4:25 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding following Resident 8's care plans. DON B indicated yes if the care plan indicates an item then the care plan should be followed. DON B stated the physician orders soul be clarified the beginning of each month. DON B also stated the physician order stated to wear a double layer of Tubigrips Resident 8 should have been wearing a double layer Tubigrips on both lower legs.

Occurrence 2
Resident 8's care plan titled "Skin Integrity", original date 1/25/12 and reviewed 8/12, Intervention dated 6/12/12 states "put legs on 2 pillow(s) when in recliner chair & (and) has legs

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F 282	Continued From page 10 up." On 9/10/12, at 10:45 AM Surveyor 29094 observed Resident 8 sitting in his recliner chair in his room, in a reclined position. Resident 8 was observed with both legs lying directly on the foot rest of the recliner. Resident 8 did not have 2 pillows under his legs. Resident 8's plan of care was not followed On 9/10/12, at 1:15 PM Surveyor 29094 observed Resident 8 sitting in his recliner chair in his room, in a reclined position. Resident 8 was observed with both legs lying directly on the foot rest of the recliner. Resident 8 did not have 2 pillows under his legs. Resident 8's plan of care was not followed On 9/11/12, at 1:45 PM Surveyor 29094 observed Resident 8 sitting in his recliner chair in his room, in a reclined position. Resident 8 was observed with both legs lying directly on the foot rest of the recliner. Resident 8 did not have 2 pillows under his legs. Resident 8's plan of care was not followed On 9/12/12 at 4:25 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding following Resident 8's care plans. DON B indicated yes if the care plan indicates an item then the care plan should be followed. DON B stated Resident 8 is at risk for skin breakdown and the foot rest of Resident 8's recliner is hard. DON B also stated she would expect Resident 8 to have a pillow under his calves when in his recliner. Example 2 (Occurrence 1)	F 282		

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Resident 9's was admitted to the facility on 11/5/11 with the following diagnoses; Dementia, history of falls, Hallucinations...

Resident 9's physician order, dated 5/14/12, states Palm protector or cone splint for right hand to decrease Contracture and risk for skin breakdown.

Resident 9's care plan titled "Skin Integrity", original date 2/7/12 and reviewed 5/1/12, Intervention dated 5/29/12 states "check under palm protector for redness or irritation. May remove for meals and hygiene."

Resident 9's care plan titled "ADL/Mobility", original date 2/7/12 and reviewed 8/12, Intervention dated 5/29/12 states "passive stretch to right hand especially ring finger prior to donning palm protector".

Resident 9's Certified Nursing Assistant (CNA) worksheet, updated 9/11/12, states "Restorative:... Palm protector to right hand remove 1 x/shift for hygiene and to complete skin check for redness or irritation. May remove during meals for self feeding and to keep clean."

On 9/10/12, at 1:10 PM Surveyor 29094 observed Resident 9 sitting in her Broda chair in the lounge across from the nursing station. Resident 9's right hand was in a closed position. Resident 9 was observed without a palm protector in her right hand. Resident 9's plan of care was not followed

On 9/10/12, at 1:30 PM Surveyor 29094 observed Resident 9 sitting in her room in her Broda chair. Resident 9 was observed without a palm

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protector in her right hand. Resident 9 was transferred to her bed by certified nursing Assistant (CNA) K. CNA K performed perineal care on Resident 9 and replaced Resident 9's adult brief and covered Resident 9. CNA K placed floor mats on both sides of Resident 9's bed and left Resident 9's room. CNA K did not place a palm protector in Resident 9's right hand. Resident 9's plan of care was not followed.

On 9/11/12, at 10:02 AM Surveyor 29094 observed Resident 9 sitting in her Broda chair in her room. Resident 9's right hand was observed without a palm protector in her right hand. Resident 9's plan of care was not followed.

On 9/11/12, at 2:00 PM Surveyor 29094 observed Resident 9 lying in her bed in her room. Resident 9's hands were visible above Resident 9's covers. Resident 9's right hand was observed without a palm protector in her right hand. Resident 9's plan of care was not followed.

On 9/12/12 at 4:25 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding following Resident 9's care plans. DON B indicated yes if the care plan indicates an item then the care plan should be followed.

Occurrence 2
Resident 9's care plan titled "Fall/Injury", original date 2/7/12 and reviewed 5/1/12, Intervention undated states "Broda w/c (wheelchair) c (with) pommel in front..."

On 9/10/12, at 1:10 PM Surveyor 29094 observed Resident 9 sitting in her Broda chair in the lounge across from the nursing station. Resident 9 was

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observed sitting on a flat cushion. Resident 9 did not have a pommel cushion in her Broda chair. Resident 9's plan of care was not followed.

On 9/10/12, at 1:30 PM Surveyor 29094 observed Resident 9 sitting in her room in her Broda chair. Resident 9 was transferred to her bed by certified nursing Assistant (CNA) K. Surveyor 29094 observed Resident 9's Broda chair cushion. Resident 9's Broda chair cushion did not have a pommel in the front. Resident 9's cushion was observed to be a flat square cushion. Resident 9's plan of care was not followed.

On 9/11/12, at 10:02 AM Surveyor 29094 observed Resident 9 sitting in her Broda in her room beside her bed. Resident 9 was observed sitting on a flat cushion. Resident 9 did not have a pommel cushion in her wheelchair. Resident 9's plan of care was not followed.

On 9/12/12 at 4:25 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding following Resident 9's care plan regarding her pommel cushion. Surveyor 29094 asked DON B if Resident 9 has a pommel cushion in her Broda chair. DON B stated Resident 9 does not have a pommel cushion in her wheel chair. DON B also indicated if the care plan indicates an item to be in place, then she would expect the care plan to be followed or a staff member to question why a device was not being used.

Occurrence 3
Resident 9's care plan titled "Alteration in Urinary Continence", original date 2/7/12 and reviewed 5/1/12, Intervention: a hand written entry, undated, states Check and change on even hours

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every 2 hours and on rounds at night.

Resident 9's Certified Nursing Assistant (CNA) worksheet, updated 9/11/12, states Toileting: incontinent. Schedule: check and change every 2 hours on even hours...

On 9/12/12, at 9:35 AM Surveyor 29094 observed Certified Nursing Assistant (CNA) C and CNA M transfer Resident 9 to her bed. CNA C removed Resident 9's adult brief. CNA C provided perineal care to Resident 9. Resident 9's new adult brief was placed. Resident 9 was transferred back into her Broda chair. Resident 9 was removed from her room to receive a telephone call at the nurses' station.

On 9/12/12, at 9:45 AM Surveyor 29094 observed Resident 9 to continue to be on the telephone at the nursing station. Resident 9 hung up the phone at 10:00 AM and was placed in the activity room to attend popcorn and cookies. Resident 9 was observed on a rotating basis by Surveyors 29094, 22597 and 27973 sitting in her Broda chair in the activity room until 11:25 AM. Resident 9 was not check for incontinence or changed during this observation period from 9:45 AM through 11:25 AM.

On 9/12/12, at 11:25 AM Surveyor 29094 observed Resident 9 being removed from the Activity room and was placed by the door of the small lounge across from the nursing station. Resident 9 sat beside the medication cart of Licensed Practical Nurse (LPN) Q. Surveyor 29094 observed Resident 9 sitting in her wheel chair across from the nurses' station until 12:05 PM. Resident 9 was not checked and changed

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with in the 2 hours or on the even hour.

On 9/12/12, at 12:05 PM Surveyor 29094 observed Resident 9 removed from the small lounge door way and placed in the dining room at Resident 9's table. Surveyor 29094 observed Resident 9 sitting in her Broda chair at her table until 12:35 PM. Resident 9 received her lunch meal and was being assisted to eat. Resident 9 was not checked and changed every 2 hours or on the even hour.

On 9/12/12, at 1:05 PM Surveyor 29094 observed Resident 9 being removed from the dining room and placed by the small lounge across from the nurses' station.

On 9/12/12, at 1:15 PM Surveyor 29094 spoke with CNA C regarding Resident 9's toileting. CNA C stated they have not checked or changed Resident 9 since before lunch. CNA C also stated they would be laying Resident 9 down and would let Surveyor 29094 know prior to transferring Resident 9 into bed. Resident 9 was not checked and changed every 2 hours or on the even hour.

On 9/12/12, at 1:45 PM CNA C approached Surveyor 29094 and states CNA J was going to transfer Resident 9 into bed now. CNA J also stated CNA J was going to do Resident 9 first and then go with Surveyor 29094 to place Resident 11 in bed.

On 9/12/12, at 1:50 AM Surveyor 29094 observed Certified Nursing Assistant (CNA) J and CNA M transferred Resident 9 into her bed. CNA J removed Resident 9's adult brief. Resident 9's adult brief was soiled with a strong odorous urine

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smell. Resident 9's adult brief was observed to be saturated with urine covering the brief area from the top of Resident 9's front perineal area to the lower back area of Resident 9's. CNA J provided Perineal care. CNA J applied Protective ointment to Resident 9's perineal area. Resident 9's new adult brief was placed.

Resident 9 did not receive toileting program of check and change every 2 hours on the even hour. Resident 9's toileting program was not completed. Resident 9's plan of care was not followed

Reference F 315

Example 3
Resident 11 was admitted to the facility on 6/15/12, with the following diagnoses; Alzheimer Disease, history of left hip fracture, Glaucoma, Hard of Hearing...

Resident 11's care plan titled "Alteration in Urinary Continence", undated, Intervention: Scheduled check and change - a hand written entry, undated, states individualized times: every 2 hours on odd hours, night rounds and as needed.

Resident 11's Certified Nursing Assistant (CNA) worksheet, updated 9/11/12, states Toileting: incontinent. Schedule: check and change every 2 hours on odd hours and night and as needed...

On 9/12/12, at 9:05 AM Surveyor 29094 observed Resident 11 removed from the dining room and placed beside his bed. Resident 11 was sitting in his high back wheelchair.

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On 9/12/12, at 9:31 AM Surveyor 29094 observed Resident 11's call light on outside Resident 11's door. Surveyor 29094 Observe Licensed Practical Nurse (LPN) Q enter Resident 11's room. LPN Q turned off Resident 11's call light and exited Resident 11's room. Resident 11's door remained open and Resident 11 remained sitting in his high back wheelchair. Resident 11 was not checked and changed on the odd hour.

On 9/12/12, at 9:31 AM Surveyor 29094 observed Resident 11's call light on outside Resident 11's door. Surveyor 29094 Observe Licensed Practical Nurse (LPN) Q enter Resident 11's room. LPN Q turned off Resident 11's call light and exited Resident 11's room. Resident 11's door remained open and Resident 11 remained sitting in his high back wheelchair.

On 9/12/12, at 9:50 AM Surveyor 29094 observed Resident 11's call light on again. CNA J entered Resident 11's room. Resident 11's door remained open. CNA J asked Resident 11 if he wanted to lie down. Resident 11 did not respond to CNA J question. CNA asked Resident 11 if her would like to go to the Activity room and have popcorn and cookies.

On 9/12/12, at 9:52 AM Surveyor 29094 observed Resident 11 removed from his room and placed in the activity room. Resident 11 was observed by Surveyors on a rotating basis by 29094, 22597 and 27973 until 11:32 AM. Resident 11 was not check for incontinence or changed during this observation period from 9:52 AM through 11:32 AM.

On 9/12/12, at 11:32 AM Surveyor 29094

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observed Resident 11 in his high back wheelchair being removed from the activity room and paced at his table in the dining room. Resident 11 remained in the dining room receiving his lunch at 12:25 PM. Resident 11 remained eating in the dining room at 12:35 PM. Resident 11 was not checked and changed every 2 hours or on the odd hour per his plan of care.

On 9/12/12, at 1:05 PM Surveyor 29094 observed Resident 11 being wheeled down to Resident 11's room in his high back wheelchair. Surveyor 29094 asked CNA C if Resident 11 had been toilet since lunch. CNA C stated no. Resident 11 was placed in his room at beside. Surveyor 29094 spoke with CNA C and informed CNA C Surveyor 29094 would like to observe Resident 11's cares with transferring and toileting. CNA C stated she would inform her co-workers and would notify Surveyor 29094 prior to placing Resident 11 in bed.

On 9/12/12, at 2:05 PM Surveyor 29094 and CNA J entered Resident 11's room. CNA C stated she was going to lie Resident 11 in bed and change his adult brief. Surveyor 29094 asked CNA J if CNA J had checked or changed Resident 11 prior to lunch or since lunch. CNA J stated no Resident 11 is a Hoyer lift with 2 people and she did not help lay Resident 11 down before now. CNA J stated she needed to go get the Hoyer lift for Resident 11. CNA J exited the room. Surveyor 29094 remained in room with Resident 11. Resident 11 was not checked and changed every 2 hours or on the odd hour per his plan of care.

On 9/12/12, at 2:10 PM CNA L and CNA S entered Resident 11's room and stated the

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F 282	Continued From page 19 afternoon shift was going to place Resident 11 in bed and change Resident 11's adult brief. CNA L and CNA S with the use of a Hoyer mechanical lift placed Resident 11 in bed. On 9/12/12, at 2:30 PM Surveyor 29094 observed CNA L removed Resident 11's urine soiled adult brief and provide perineal care. Resident 11's adult brief was heavily soiled with strong odorous urine. CNA L with a wet wash cloth provided perineal care to Resident 11. Resident 11's scrotum was bright red in color with a wrinkled maceration appearance. CNA L provided perineal care. Resident 11 remained lying in his bed. Resident 11 did not receive toileting program of check and change every 2 hours or on the odd hour. Resident 11's toileting program was not completed so Resident 11's plan of care was not followed	F 282		
F 285 SS=D	Reference F 315 483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 285		

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F 285	Continued From page 20 State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Surveyor: 22597 Based on record review and interview the facility did not complete the pre-admission screening and resident review for 2 of 15 residents (Residents 2 and 3).	F 285		

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F 285	Continued From page 21 Resident 2's pre-admission screening and resident review was not completed after the 30 day exemption expired. Resident 3's pre-admission screening and resident review was not completed after the 7 day emergency placement expired. This is evidenced by the following: Example 1 Resident 2 was admitted to the facility on 3/23/11 with diagnoses that include Depression. The facility completed a Pre-Admission Screen and Resident Review (PASARR) Level 1 on 3/23/11 and indicated Resident 2 is suspected of have a serious mental illness. The form indicates the facility requested a 30 day hospital discharge exemption from completing the Level 2 screen. On 9/10/12 Surveyor 22597 was not able to locate the Level 2 PASARR screen for Resident 2. On 9/12/12, at 9:54 AM, Surveyor 22597 interviewed Social Worker (SW) G. SW G stated she is responsible for completing the Level 2 screening for residents. SW G stated she was not working at the facility when Resident 2 was admitted but she does a quarterly review of each residents' PASARR. On 9/12/12, at 12:35 PM, SW G informed Surveyor 22597 that she contacted the appropriate agency and confirmed a Level 2 was never completed for Resident 2 and SW G stated she would submit it immediately.	F 285		

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F 285	Continued From page 22 Example 2 Resident 3 was admitted to the facility on 4/11/11 with diagnoses that include Depression. The facility completed a Pre-Admission Screen and Resident Review (PASARR) Level 1 on 4/11/11 and indicated Resident 3 is suspected of have a serious mental illness. The form indicates the facility requested a 7 day emergency placement exemption from completing the Level 2 screen. On 9/10/12 Surveyor 22597 was not able to locate the Level 2 PASARR screen for Resident 3. On 9/12/12, at 9:54 AM, Surveyor 22597 interviewed Social Worker (SW) G. SW G stated she is responsible for completing the Level 2 screening for residents. SW G stated she was not working at the facility when Resident 3 was admitted but she does a quarterly review of each residents' PASARR. On 9/12/12, at 12:35 PM, SW G informed Surveyor 22597 that she contacted the appropriate agency and confirmed a Level 2 was never completed for Resident 3 and SW G stated she would submit it immediately.	F 285		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Surveyor: 29094

Based on interview and record review the facility did not ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible for 2 residents out of 12 reviewed (Residents 9 and 11) for incontinence.

Resident 9 is incontinent of bladder. The facility did not complete an accurate and thorough bowel and bladder assessment to develop an accurate individualized care plan for Resident 9. Resident 9 was not checked and changed per her toileting schedule for approximately 4 hours.

Staff did not toilet and/or check & change Resident 11 for approximately 5 hours.

This is evidence by:

According to the American Medical Directors Association (AMDA) Clinical Practice Guideline for Urinary Incontinence, "...urinary incontinence may be associated with negative outcomes, including falls and numerous psychological effects..." The Clinical Practice Guidelines indicate that, "...Urinary incontinence...can often be managed and modified, and in some cases

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reversed, even in frail older adults and individuals with dementia..." The Clinical Practice Guidelines indicated, "...Urinary incontinence is identified by direct observation...Document any signs and symptoms of urinary incontinence in the patient's medical record. Documentation should include details such as the related circumstances...the frequency of incontinence episodes, the time of day or night...A bladder record or voiding diary may help to characterize the patient's incontinence..."

According to WOCN (Wound Ostomy and Continence Nurses Society), reversible causes of incontinence include: delirium, infection, medications, bladder irritants, vaginitis, pharmaceuticals, polyuria, retention, constipation, environmental barriers, and physical limitations. Assessment of these factors is needed to determine a plan of care that could include bladder retraining, prompted voiding, and individualized scheduled toileting. This individualized schedule should be used rather than the facility's incontinence management toileting schedule currently being used for all cognitively impaired and incontinent residents who are unable to communicate with staff that they have to go to the bathroom.

The outcome of incontinence services can be determined by recognition of the problem, nursing assessment, and referral for diagnostic evaluation and treatment. All residents with incontinence should be evaluated for causative factors, as treatment is dependent on these factors. However, before successful treatments can be initiated, the problem needs to be identified. The identifying of the type of

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incontinence is essential in a multidisciplinary collaboration for both the assessment of the individual and the treatment of urinary incontinence. The treatment modalities are different for stress incontinence, functional incontinence, overflow incontinence, urge incontinence, and mixed incontinence.

The goal should be to restore as much normal bladder function as possible for each resident by decreasing or eliminating the incontinent episodes. This promotes dignity, reduces risk factors for skin breakdown, and reduces the incidents of urinary tract infection.

The facility policy titled "urinary Incontinence", dated 9/05 and revised 1/09, states Policy: The corporation thrives to ensure that residents who are incontinent of bladder receive appropriate treatment and services to restore as much normal bladder function as possible and to provide treatment and services to prevent urinary tract infections... Procedure: preventing skin changes, skin irritation or breakdown in the course of developing and implementing a urinary management program to achieve the highest practical level of urinary continence, it is important to involve the resident and/or his or her surrogate in care decisions. In order for a resident to exercise his or her right appropriate to make informed choices about care and treatment or to refuse treatment, the center and the resident must discuss the resident's condition, treatment options, and consequences of refusing treatment. the center should address the resident's concerns and offer alternatives for management of urinary incontinence, if the resident has refused specific treatment.... Programs that are dependent on

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staff involvement and assistance:1. Prompted voiding is a behavioral technique appropriate for use with dependent and more cognitively impaired residents... Scheduled voiding/habit training is a behavioral technique that calls for scheduled toileting at regular interval on a planned basis to match the residents voiding habits... Habit training includes timed voiding with the intervals based on the resident's usual voiding schedule or pattern... Residents who cannot self toilet may be candidates for habit training or scheduled voiding programs. 2. Scheduled check and change program may be an appropriate program for residents who are unable to use a toilet, commode, or bedpan. This program uses absorbent products and/or external collection devices...

Example 1
Resident 9's was admitted to the facility on 11/5/11 with the following diagnoses; Dementia, history of falls, Hallucinations...

Resident 9's care plan titled "Alteration in Urinary Continence", original date 2/7/12 and reviewed 5/1/12, Intervention: a hand written entry, undated, states Check and change on even hours every 2 hours and on rounds at night.

Resident 9's Certified Nursing Assistant (CNA) worksheet, updated 9/11/12, states Toileting: incontinent. Schedule: check and change every 2 hours on even hours...

Resident 9's admission Minimum Data Set (MDS), dated 11/15/11, states Resident 9 is verbally able to make self understood to express ideas and wants. Resident 9 is able to clearly

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comprehend understand others verbal content. Resident 9's cognitive score is a 15 which indicates Resident 9 is cognitively intact. Resident 9 needs extensive assist with transfer and toilet use. Resident 9 is not currently on a toileting program. Resident 9's urinary continence is frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding.)

Resident 9's quarterly Minimum Data Set (MDS), dated 5/14/12, states Resident 9 is verbally able to make self understood to express ideas and wants. Resident 9 is able to clearly comprehend understand others verbal content. Resident 9's cognitive score is a 7 which indicates Resident 9 is cognitively impaired. Resident 9 needs extensive assist with transfer and toilet use. Resident 9 is not currently on a toileting program. Resident 9's urinary continence is frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding.). Resident 9's care plan states Resident 9 is on a check and change program. No changes were made in Resident 9's toileting program.

Resident 9's quarterly Minimum Data Set (MDS), dated assessment reference date of 7/31/12, states Resident 9 is usually able to make self understood to express ideas and wants. Resident 9 is able to usually able to comprehend understand others verbal content. Resident 9's cognitive score is a 1 which indicates Resident 9 is cognitively impaired. Resident 9 needs extensive assist with transfer and toilet use. Resident 9 is not currently on a toileting program. Resident 9's urinary continence is always

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incontinent. Resident 9 had a decline from 5/14/12 assessment. Resident 9's MDS indicates Resident 9 was not placed on a toileting schedule since Resident 9's admission on 11/5/11. Resident 9's care plan indicates Resident 9 is on a check and change program. No changes have been made to Resident 9's plan of care with the decline in bladder function.

Resident 9's Care Area Assessments (CAAS), dated 11/11/11, states urinary Incontinence: Review of indicators of Urinary Incontinence; 1. Modifiable factors: An X is placed in the box marked "None of the above". 2. Other factors: An X is placed in the box marked "None of the above". 3. Laboratory test: An X is placed in the box marked "None of the above". 4. Disease and conditions: An X is placed in the box marked "None of the above". 5. Type of incontinence: An X is placed in the box marked "None of the above". 6. Medications: An X is placed in the box marked "None of the above"... 8. Input from Resident and/or family representative regarding the care area: "None". 9. Analysis of findings; Document; description of problem, causes and contributing factor: Frequently incontinent per care tracker (computerized charting for activities of daily living). 10. Care Plan: Yes. 11. Document reasons care plan will be developed; Proceed to urinary care plan approaches and toileting schedule.

Resident 9's Bladder Data collection and assessment form, dated 11/10/11, indicates 1. Admission information regarding urinary continence status: A Resident 9 has been incontinent the past 7 days. B. Review the last seven days of voiding documentation: Frequently

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incontinent. C. Signs and symptoms of urinary incontinence: "Clothes wet". 2. Potential reversible causes of urinary incontinence (check all that apply): Delirium and a handwritten entry stating hallucinations 3. Contributing Diagnosis/Medical conditions 9 check all that apply: This area of the assessment is blank. 4. Medication that may be contributing to bladder dysfunction (check all that apply): This area of the assessment is blank. 5. Further information: This area of the assessment is blank... 7. Incontinence Symptoms profile (check all that apply);... This area of the assessment is blank. 8. Treatment/management program placement: A... Type of incontinence:...an X is placed in the box stating " not appropriate for toileting or retraining program: Scheduled check and change." Residents who cannot sit on the toilet or commode may be candidates... D. Provide rationale if resident is not appropriate for program due to: A X is placed in the box stating "Inability to follow direction" Resident 9's cognitive status on MDS, dated 11/11/11 indicates Resident 9's is able to follow direction and memory is intact. (It is important to note the box stating inability to sit on toilet or commode is not checked.) E. Additional notes; (include analysis of three day elimination tracking): This area is left blank. Resident 9's bladder data collection and assessment does not identify that Resident 9's should not be placed on the toilet or the reason Resident 9 who is a one person stand transfer is on a check and change program. An analysis of the 3 day elimination was not addressed on the assessment. Resident 9 showed evidence on her 3 day elimination of a schedule of being dry and incontinent. Resident 9 was not placed on a bladder program to maintain or increase her incontinence status.

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Resident 9's 3 day elimination tracking chart, dated 11/7/11 through 11/10/11, states Resident 9 had 14 dry episodes in 4 days, dry and toilet/used device had 4 episodes in 2 days, and Resident 9 had 9 episodes of incontinence in 3 days. A hand written entry across the top of the tracking chart states "incontinent". Resident 9's 3 day elimination tracking states on 11/7/12 Resident 9 was tracked 2 times on the night shift, 4 times on the day shift and 3 times on the PM shift. (Resident 9 tracking chart states Resident 9 had 3 episodes of incontinent and was dry and toilet on 6 other episodes.) On 11/8/11 Resident 9 was toileted 2 times on the night shift, 4 times on the day shift and 3 times on the PM shift. (Resident 9 tracking chart states Resident 9 had 3 episodes of incontinent and was dry and toileted on 6 other episodes.) On 11/9/11 Resident was toileted 1 time on the night shift, 4 times on the day shift and 3 times on the PM shift. (Resident 9 tracking chart states Resident 9 had 4 episodes of incontinent and was dry on 4 other episodes.) On 11/10/11 Resident 9 was dry at 11:00 PM and 1:00 AM. There is no other entries document for 11/10/11. Resident 9 was incontinent 10 times during this 3 day observation period.

Surveyor 29094 requested Resident 9's 5/12 bladder assessment form. Surveyor 29094 received Bladder data collection and assessment dated 11/10/11. On page 3 of the bladder data assessment form states: Reviews (admissions quarterly ... change of condition of new onset of incontinence.) Date reviewed- 6/14/12. Reason for review- Quarterly. Able to participate in bladder program: "No". No further information was provided for this review or Resident 9's

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bladder collection and assessment. Resident 9 showed a decline in her 3 day elimination diary from 11/10/11.

Resident 9's 3 day elimination tracking chart, dated 5/2/12 through 5/5/12, states Resident 9 had 2 dry episodes in 1 days, dry and toilet/used device had 7 episodes in 2 days. Resident 9 had 11 episodes of incontinence in 4 days, Resident 9 was incontinent of urine and refused to toilet 3 times in 2 days and was incontinent and toilet used 5 times in 2 days. A hand written entry across the top of the tracking chart states "inc (incontinent) urine". Resident 9's 3 day elimination tracking states on 5/2/12 Resident 9 was tracked 3 incontinent episodes on the PM shift. On 5/3/12 Resident 9 was toileted 2 times on the night shift, 4 times on the day shift and 3 times on the PM shift. (Resident 9 tracking chart states Resident 9 had 6 episodes of incontinent and was dry and toileted on 3 other episodes.) On 5/4/12 Resident 9 was toileted 2 times on the night shift, 4 times on the day shift and 3 times on the PM shift. (Resident 9 tracking chart states Resident 9 had 7 episodes of incontinent and was dry on 2 other episodes.) On 5/5/12 Resident 9 was toileted 2 time on the night shift and 4 times on the day shift. (Resident 9 tracking chart states Resident 9 had 2 episodes of incontinence and 4 episodes of dry and toileted.) Resident 9 was incontinent 19 times during this tracking observation period. Resident 9 showed a decline in incontinence from the 11/10/11 observation tracking form. Resident 9 was kept on a check and change program according to Resident 9 plan of care.

Resident 9's Bladder Data collection and

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assessment form, dated 8/15/12, indicates 1. Admission information regarding urinary continence status: A Resident 9 has been incontinent the past 7 days. B. Review the lat seven days of voiding documentation: Always incontinent. Across the form a handwritten entry is written "Incontinent". C. Signs and symptoms of urinary incontinence: "Clothes wet". 2. Potential reversible causes of urinary incontinence (check all that apply): This area of the assessment is blank. 3. Contributing Diagnosis/Medical conditions 9 check all that apply: This area of the assessment is blank. 4. Medication that may be contributing to bladder dysfunction (check all that apply): This area of the assessment is blank. 5. Further information: This area of the assessment is blank... 7. Incontinence Symptoms profile (check all that apply);... D. Functional urinary incontinence: A check mark is placed in the box marked "Dementia" no other boxes are checked. 8. Treatment/management program placement: A... Type of incontinence: Functional. B Treatment program: the options list under this section include a. Scheduled voiding/habit training. b. Prompted voiding. c. Bladder training. d. Scheduled check and change. There is not a check mark placed in a box to identify Resident 9's treatment program... D. provide rationale if resident is not appropriate for program due to: A line is placed in the box stating "Cognitive Impairment". (It is important to note the box stating inability to sit on toilet or commode is not checked.) E. Additional notes; (include analysis of three day elimination tracking): This area is left blank. Resident 9's bladder data collection and assessment does not identify the type of program Resident 9's should be on or the reason Resident 9 who is a one person stand transfer is on a

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check and change program.

Resident 9's Bowel and Bladder chart detail report, dated 7/27/12 through 8/14/12, states the following a hand written entry on the top right side of the form indicates Resident 9 is "Always Incontinent of Bowel and Bladder." Resident 9's Bladder chart detail report also states Resident 9 had 69 incontinent episodes on 55 shifts from 7/27/12 through 8/14/12 (19 days). Resident 9's Bladder chart detail does not indicate when Resident 9 was checked for incontinence and dry.

On 9/ 12/12, at 4:45 PM Surveyor 29094 requested Resident 9's 3 day voiding diaries for 11/10/11 and 8/15/12 from Director of Nursing (DON) B. Surveyor 29094 received 3 day voiding diary for 5/21/12 and 11/10/11. A 3 day elimination diary for 8/15/12 assessment was not provided to Surveyor 29094. No further information was provided to Surveyor 29094.

On 9/12/12, at 9:35 AM Surveyor 29094 observed Certified Nursing Assistant (CNA) C and CNA M transfer Resident 9 to her bed. CNA C removed Resident 9's adult brief and provided peri rectal care to Resident 9. Resident 9 had smeared Bowel movement (BM) wiped from her peri rectal area. CNA C using the same gloves with observed BM on the right thumb of CNA C's glove rolled Resident 9 onto her back and provided front perineal care to Resident 9. Resident 9's new adult brief was placed. Resident 9 was transferred back into her Broda chair. Resident 9 was removed from her room to receive a telephone call at the nurses' station.

On 9/12/12, at 9:45 AM Surveyor 29094 observed

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Resident 9 to continue to be on the telephone at the nursing station. Resident 9 hung up the phone at 10:00 AM and was placed in the activity room to attend popcorn and cookies. Surveyor 29094, 22597 and 27973 rotated observations of Resident 9 sitting in her wheel chair in the Activity room until 11:25 AM.

On 9/12/12, at 11:25 AM Surveyor 29094 observed Resident 9 being removed from the Activity room and was placed by the door of the small lounge across from the nursing station. Resident 9 sat beside the medication cart of Licensed Practical Nurse (LPN) Q. Surveyor 29094 observed Resident 9 sitting in her Broda chair across from the nurses' station until 12:05 PM

On 9/12/12, at 12:05 PM Surveyor 29094 observed Resident 9 removed from the small lounge door way and placed in the dining room at Resident 9's table. Surveyor 29094 observed Resident 9 sitting in her Broda chair at her table until 12:35 PM. Resident 9 received her lunch meal and was being assisted to eat.

On 9/12/12, at 1:05 PM Surveyor 29094 observed Resident 9 being removed from the dining room and placed by the small lounge across from the nurses' station.

On 9/12/12, at 1:15 PM Surveyor 29094 spoke with CNA C regarding Resident 9's toileting. CNA C stated they have not checked or changed Resident 9 since before lunch. CNA C also stated they would be laying Resident 9 down and would let Surveyor 29094 know prior to transferring Resident 9 into bed.

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F 315	Continued From page 35 On 9/12/12, at 1:45 PM CNA C approached Surveyor 29094 and states CNA J was going to transfer Resident 9 into bed now. CNA J also stated CNA J was going to do Resident 9 first and then go with Surveyor 29094 to place Resident 11 in bed. On 9/12/12, at 1:50 AM Surveyor 29094 observed Certified Nursing Assistant (CNA) J and CNA M transferred Resident 9 into her bed. CNA J removed Resident 9's adult brief. Resident 9's adult brief was heavily saturated with a strong odorous urine. Resident 9's adult brief was observed to be saturated with urine covering the brief area from the top of Resident 9's front perineal area to the lower back area of Resident 9. Resident 9's perineal area was bright red in color covering her entire perineal area. Resident 9's lower perineal to peri rectal area was wrinkled in a macerated appearance. CNA J stated to CNA M Resident 9 is very red. CNA J applied Protective ointment to Resident 9's perineal area. CNA J placed a new adult brief on Resident 9. On 9/12/12, at 2:00 PM Surveyor 29094 spoke with CNA J and CNA M regarding Resident 9's toilet use. CNA J and CNA M stated No Resident 9 was not checked or changed prior to lunch or since lunch was completed. Surveyor 29094 asked CNA J and CNA M if Resident 9 ever is placed on the toilet. CNA J and CNA M stated they never place Resident 9 on the toilet. Surveyor 29094 asked CNA J and CNA M could Resident 9 sit on the toilet. CNA J and CNA M stated, "Yes, but they never place (Resident 9) on the toilet due to her care plan states check and change." CNA J stated the care plan would state	F 315		

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toilet if she was to be placed on the toilet.

Resident 9 did not receive toileting program of check and change every 2 hours on the even hour. Resident 9's toileting program was not completed since 9:35 AM until 1:45 PM approximately 4 hours. Resident 9's plan of care was not followed. Resident 9's assessment does not evaluate Resident 9's 3 day diary or assess Resident 9's ability to be placed on the toilet to increase Resident 9's continence status.

On 9/12/12, at 4:45 PM Surveyor 29094 informed Director of Nursing (DON) B regarding Resident 9's observation of not being toileted for approximately 4 hours and Resident 9's bright red perineal. DON B stated she was aware of Resident 9's red perineal on 9/11/12, and would have expected the nurses to be sure Resident 9 was toilet and perineal area checked due to redness.

On 9/12/12, at 4:45 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding Residents placed on a check and change program and Resident 9's toileting schedule. DON B stated Residents who are placed on a toileting schedule are only resident who are dependent with transfers with use of a Hoyer lift and those who are unable to sit on the toilet. DON B also stated Resident 9 is a one person pivot transfer and is able to sit on the toilet. DON B stated Resident 9 should be placed on the toilet during the day and not just to be a check and change. DON B continue to stated she would expect the staff to follow Resident 9's care plan and at a minimum check and change Resident 9 every 2 hours as per her plan of care. DON B

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stated Resident 9's bowel and bladder assessment needs to be reviewed and followed.

Example 2
Resident 11 was admitted to the facility on 6/15/12, with the following diagnoses; Alzheimer Disease, history of left hip fracture, Glaucoma, Hard of Hearing...

Resident 11's care plan titled "Alteration in Urinary Continence", undated, Intervention: Scheduled check and change - a hand written entry, undated, states individualized times: every 2 hours on odd hours, night rounds and as needed.

Resident 11's Certified Nursing Assistant (CNA) worksheet, updated 9/11/12, states Toileting: incontinent. Schedule: check and change every 2 hours on odd hours and night and as needed...

Resident 11's Bladder Data collection and assessment form, dated 7/8/12, indicates 1. Admission information regarding urinary continence status: A. Resident 11 has been incontinent the past 7 days. B. Review the last seven days of voiding documentation: Always incontinent. Across the form a handwritten entry is written "Incontinent". C. Signs and symptoms of urinary incontinence: "Wears pads, tissue or cloth in underwear to catch urine." 2. Potential reversible causes of urinary incontinence (check all that apply): Dependent transfer, and impaired mobility /ambulation. 3. Contributing Diagnosis/Medical conditions: check all that apply: Alzheimer's disease/Dementia. 4. Medication that may be contributing to bladder dysfunction (check all that apply): This area of the assessment is blank... 7. Incontinence Symptoms

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profile (check all that apply);... D. Functional urinary incontinence: A check mark is placed in the box marked Mobility/ manual dexterity impairments, lack of ability to get to toilet... unwilling to participate, and Dementia. 8. Treatment/management program placement: A... Type of incontinence: Functional. B Treatment program: the options list under this section include a. Scheduled voiding/habit training. b. Prompted voiding. c. Bladder training. d. Scheduled check and change. There is not a check mark placed in a box to identify Resident 9's treatment program... D. provide rationale if resident is not appropriate for program due to: A line is placed in the box stating "Cognitive Impairment". (It is important to note the box stating inability to sit on toilet or commode is not checked.) E. Additional notes; (include analysis of three day elimination tracking): a note which states: scheduled check and change on odd hours, night rounds and as needed.

Resident 11's admission Minimum Data Set (MDS), dated 6/27/12, states Resident 11 is sometimes able to make self understood to express ideas and wants. Resident 11 is sometimes able to understand others verbal content. Resident 11's cognitive score is a 1 which indicates Resident 11 is cognitively impaired. Resident 11 needs extensive with transfer and toilet use. Resident 11 is not currently on a toileting program. Resident 11's urinary continence is frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding.)

On 9/12/12, at 8:25 AM Surveyor 29094 observed Resident 11 sitting in his high back wheelchair in

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the dining room sleeping with breakfast of 1 egg and oatmeal in front of Resident 11.

On 9/12/12, at 9:05 AM Surveyor 29094 observed Resident 11 removed from the dining room and placed beside his bed. Resident 11 was sitting in his high back wheelchair.

On 9/12/12, at 9:31 AM Surveyor 29094 observed Resident 11's call light on outside Resident 11's door. Surveyor 29094 Observe Licensed Practical Nurse (LPN) Q enter Resident 11's room. LPN Q turned off Resident 11's call light and exited Resident 11's room. Resident 11's door remained open and Resident 11 remained sitting in his high back wheelchair. Resident 11 was not checked or changed for urinary incontinence.

On 9/12/12, at 9:50 AM Surveyor 29094 observed Resident 11's call light on again. CNA J entered Resident 11's room. Resident 11's door remained open. CNA J asked Resident 11 if he wanted to lie down. Resident 11 did not respond to CNA J question. CNA asked Resident 11 if he would like to go to the Activity room and have popcorn and cookies. Resident 11 was not checked or changed for urinary incontinence.

On 9/12/12, at 9:52 AM Surveyor 29094 observed Resident 11 removed from his room and placed in the activity room. Surveyor 29094, 22597 and 27973 rotated observations of Resident 11 sitting in his wheel chair in the Activity room until 11:32 AM. Resident 11 was not check for incontinence or changed during this observation.

On 9/12/12, at 11:32 AM Surveyor 29094 observed Resident 11 in his high back wheelchair

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being removed from the activity room and paced at his table in the dining room. Resident 11 remained in the dining room receiving his lunch at 12:25 PM. Resident 11 remained eating in the dining room at 12:35 PM.

On 9/12/12, at 1:05 PM Surveyor 29094 observed Resident 11 being wheeled down to Resident 11's room in his high back wheelchair. Surveyor 29094 asked CNA C if Resident 11 had been toilet since lunch. CNA C stated no. Resident 11 was placed in his room at beside. Surveyor 29094 spoke with CNA C and informed CNA C Surveyor 29094 would like to observe Resident 11's cares with transferring and toileting. CNA C stated she would inform her co-workers and would notify Surveyor 29094 prior to placing Resident 11 in bed.

On 9/12/12, at 2:05 PM Surveyor 29094 and CNA J entered Resident 11's room. CNA J stated she was going to lie Resident 11 in bed and change his adult brief. Surveyor 29094 asked CNA J if CNA J had checked or changed Resident 11 prior to lunch or since lunch. CNA J stated no Resident 11 is a Hoyer lift with 2 people and she did not help lay Resident 11 down before now. CNA J stated she needed to go get the Hoyer lift for Resident 11. CNA J exited the room. Surveyor 29094 remained in room with Resident 11.

On 9/12/12, at 2:10 PM CNA L and CNA S entered Resident 11's room and stated the afternoon shift was going to place Resident 11 in bed and change Resident 11's adult brief. CNA L and CNA S with the use of a Hoyer mechanical lift placed Resident 11 in bed.

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On 9/12/12, at 2:30 PM Surveyor 29094 observed CNA L removed Resident 11's urine soiled adult brief and provide perineal care. Resident 11's adult brief was heavily soiled with strong odorous urine. CNA L with a wet wash cloth provided perineal care to Resident 11. Resident 11's scrotum was bright red in color with a wrinkled maceration appearance. Resident 11 also was observed to have an approximately a 0.4 centimeter round dark red blister appearance area in the center of Resident 11's pubis area. CNA L cleanse Resident 11's scrotum area with the wet wash cloth. Resident 11 yelled out with a facial grimace and pulled scrotum area away from Resident 11 CNA L asked resident 11 if his scrotum hurt Resident 11 stated yes. CNA L attempted a second time to cleanse Resident 11's scrotum. Resident 11 again yelled out and moved away from CNA L. CNA L stated Resident 11's scrotum and groin is very red. CNA L applied protective barrier ointment to Resident 11 CNA L replaced a clean adult brief on Resident 11.

On 9/12/12, at 3:28 PM Surveyor 29094 and Assistant Director of Nursing (ADON) H observed Resident 11's pubis blistered appearance area. ADON H stated the area was some type of boil. ADON H also stated Resident 11's area could be cause by moisture due to wearing adult briefs and cloth against Resident 11's skin.

Resident 11 did not receive toileting program of check and change every 2 hours on the odd hour. Resident 11's toileting program was not completed for approximately 5 hours, and Resident 11's plan of care was not followed.

On 9/12/12, at 4:45 PM Surveyor 29094 spoke

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F 315	Continued From page 42 with Director of Nursing (DON) B regarding Resident 11's red Scrotum area and not being checked and changed for 5 hours. DON B stated she would expect Resident 11 to be checked and changed on the odd hour as per his plan of care.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 29094 Based on observation, interview and record review the facility did not ensure that the residents environment remains free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents in 2 of 15 (Residents 11 and 10) residents reviewed. Surveyor 29094 observed a clip alarm attached to Resident 11's wheelchair; the alarm was not clipped to Resident 11. Resident 11 has a history of falls. Resident 10's call light was not placed in reach after she was provided cares. This is evidence by:	F 323		

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Example 1
Resident 11 was admitted to the facility on 6/15/12, with the following diagnoses; Alzheimer Disease, history of left hip fracture, Glaucoma, Hard of Hearing...

Resident 11's care plan titled "Fall/Injury", dated 6/16/12, indicates Fall injury risk related to: A. Musculoskeletal; Pain, Stiffness, and Osteoarthritis. B. Medical factors: Bowel incontinence, Bladder incontinence. C. Cognitive Impairment: Dementia, Alzheimer's. D. Sensory impairment: hearing... Goal: Resident 11 with limit the number of falls or injury with the use of "alarms". Interventions; Enablers; Chair alarm.

Resident 11's nursing notes, dated 7/10/12, at 7:15 AM Resident 11 was found on his left side on his mat on the side of the bed...

Resident 11's nursing note, dated 7/13/12, at 4:45 AM, upon entering Resident 11's room. Resident 11 was noted on bed side mat on his hands and knees...

Resident 11's nursing notes, dated 9/11/12, at 2:30 AM, indicates Resident 11 rolled out of bed...

On 9/11/12, at 10:00 AM Surveyor 29094 observed Resident 11 sitting in his wheelchair in the hallway. Surveyor 29094 observed no facility staff present in the hallway. Resident 11's clip alarm clip was attached to the clip alarm on the back of Resident 11's wheelchair. Resident 11's clip alarm was not attached to Resident 11.

On 9/11/12, at 10:02 AM Surveyor 29094

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observed Registered Nurse (RN) T enter the Deerpath hallway towards Resident 11. Surveyor 29094 asked RN T if Resident 11 should have the clip alarm attached to Resident 11. RN T stated yes the clip alarm is to be attached to Resident 11. RN T removed the clip from the clip alarm box and attached the clip alarm to Resident 11.

On 9/12/12, at 4:45 PM, Surveyor 29094 spoke with Director of Nursing (DON) B regarding Resident 11's clip alarm. DON B stated yes Resident 11's clip alarm is to be attached whenever Resident 11 is in his wheelchair. Surveyor: 27973

Example 2
Resident 10's "Fall/Injury Assessment: Prevention and Management Plan of Care" dated 6/12 states, "...Fall/Injury Risk related to: back pain...Medical Factors: Bowel incontinence, Bladder incontinence...interventions: Keep frequently used items within reach, (call light, i.e.)..."

On 9/12/12 at 8:50 AM, Surveyor 27973 observed Certified Nursing Assistant (CNA) C and CNA J assist Resident 10 with toileting. After toileting was completed in the bathroom, CNA C pushed Resident 10 near her bed and then exited the room. CNA C did not ensure that Resident 10 had access to her call light. Resident 10's call light was located in the middle of the bed, under a blanket. Resident 10 did not have access to her call light when CNA C and CNA J exited Resident 10's room.

Surveyor 27973 spoke with Director of Nursing (DON) B on 9/12/12 at 2:30 PM. Surveyor 27973

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F 323	Continued From page 45 asked DON B if call lights should be placed in reach for resident use. DON B stated, "of course."	F 323		
F 325 SS=D	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: Surveyor: 27973 Based on observation, interview and record review, the facility to not ensure that based on a resident's comprehensive assessment, each resident receives a therapeutic diet when there is a nutritional problem for 1 of 3 residents reviewed for nutrition (Resident 5). Resident 5 was not provided supplement drinks as ordered by her physician. The facility inaccurately documented the amount of supplements consumed by Resident 5. Resident 5's care plan was not updated to indicate that she should receive a snack. This is evidenced by:	F 325		

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The facility's policy and procedure titled "Nutritional Status" effective April, 2012 states the following: "...2. Monitor food intake of meals for all residents to determine, if intake is adequate to meet needs. a. Monitor the resident's intake for changes such as refusal of most of meals offered...c. If new risk factors are identified, new interventions may be implemented and the appropriate clinicians will be notified for further assessment...6. Develop and implement individualized interventions based on interdisciplinary assessments and resident and family goals which promote the highest level of function and dignity which may include, but not limited to: Encourage residents to consume all food and fluids during meals...13. Review and revise the Nutritional Risks Plan of Care as needed..."

Resident 5 has diagnoses of diverticula of colon according to Face Sheet.

According to Resident Weight Workbook, the facility obtained the following weights for Resident 5:
May 2012: 111 pounds
June 2012: 106 pounds
July 2012: 108 pounds
August 2012: 105 pounds
September 2012: 106 pounds

Resident 5's signed Physician Orders for September, 2012 states the following: "Supplements: Super Mild 2X (times) daily w/ (with) meals; 206 Juice 3X Daily-Brkfst (Breakfast)/Lunch/Dinner; Med Pass Supplement 120 cc 3X daily (AM/Noon/Pm) ..."

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A Physician's Telephone Order, dated 7/20/12 states, "Continue to offer supplements. Snack of choice."

The facility completed a "Nutrition and Hydration Risk Assessment" dated 8/14/12 which states that Resident 5 has risk factors of poor food intake, poor fluid intake and history of urinary tract infections.

Resident 5's "Nutritional Risks Plan of Care" dated 12/18/11 states the following interventions: "...assist with meals as needed, set up...supplements as ordered: medpass 4 oz TID (three times per day)206 Juice TID ...provided fortified foods PRN (as needed) super milk TID..." Resident 5's plan of care does not indicate that Resident 5 is to receive a snack of her choice.

A Physician Order Fax dated 7/19/12 states, "Resident's wt (weight) down 5# (pounds) X 1 week c (with) reweight done. Appetite fair and unchanged. Continues to be offered supplements. Will try snack of choice. Fluid intake slightly low. Please advise any ?'s (changes). Physician order/response: As above." This intervention for snack of choice was not added to Resident 5's plan of care.

During lunch on 9/10/12 at 12:55 PM, Surveyor 27973 noted that Resident 5 had a mug of what appeared to be chocolate milk about two feet in front of her. This mug was covered and labeled with Resident 5's name. At 1:00 PM, Surveyor 27973 noted that Resident 5's mug remained covered and approximately two feet from her. At

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this time, Surveyor 27973 asked Certified Nursing Assistant (CNA) K about Resident 5's drink. CNA K stated that she thought it was just milk and then assisted Resident 5 with the drink. Resident 5 was not provided with the 206 juice at the lunch meal, per her Physician's orders.

During the breakfast meal on 9/11/12 at 8:10 AM, Surveyor 27973 observed that Resident 5 had a mug of the super milk and a mug of the 206 juice. Surveyor 27973 noted that Licensed Practical Nurse (LPN) N was assisting residents sitting at the same table as Resident 5, but did not assist or encourage Resident 5 with eating or drinking her supplements at 8:44 AM. At 8:50 AM, CNA P encouraged Resident 5 to drink her coffee but did not cue or encourage Resident 5 to drink her supplements. Surveyor 27973 observed that Resident 5 was removed from the dining room at 9:05 AM. During this continuous observation of Resident 5's breakfast meal, staffs did not encourage Resident 5 to drink her 206 juice supplement or Super Milk. Surveyor 27973 noted that Resident 5 did not drink any of her Super Milk or 206 juice drink.

Resident 5's Medication Administration Record (MAR) for September, 2012 states the following: "Super Milk 2X Daily w/meals...Brkfst; % (percentage consumed) ... 9/10/12: 0; 9/11/12:50 (percent)." It is important to note that Resident 5 did not consume any portion of her Super Milk during the 9/11/12 breakfast meal.

Resident 5's MAR for September, 2012 states, "206 Juice 3X Daily-BRKFST/Lunch/Dinner; Lunch...%...9/10/12: 0; 9/11/12: (not documented)..." It is important to note that

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Resident 5 was not served her 206 juice drink during the 9/10/11 lunch meal.

On 9/12/12 Surveyor 27973 spoke with CNA R about meal documentation. CNA R stated that the CNAs record the meal intakes on a worksheet and keep it in a drawer in the main dining room. Surveyor 27973 asked if while recording the fluids consumed for a Resident if she separately writes down the supplements consumed from the regular fluids consumed. CNA R stated that she writes down the supplements separate.

Review of these intakes for Resident 5 on 9/10/12 indicates that Resident 5 consumed 50 milliliters (mL) of fluids at lunch. The worksheet for 9/11/12 indicates that Resident 5 consumed 100 mL of fluids at the breakfast meal.

Surveyor 27973 spoke with LPN Q on 9/12/12 at 10:58 AM about the process for documenting supplement intakes in the MAR. LPN Q stated that she usually looks in the dining room to see what is consumed. LPN Q stated that she does not know if everyone does it this way and that she would ask the aides if she does not get into the dining room to see for herself.

Surveyor 27973 spoke with Registered Dietician (RD) E on 9/12/12 at 3:50 PM. RD E stated that Resident 5 is getting the 206 drink between meals and could be getting it with snacks as well. Surveyor 27973 requested evidence that this was the case. Surveyor 27973 informed RD E of her observations of Resident 5 not getting her supplement and not getting assistance with her supplements and the documentation of in the MAR. RD E stated that she did not know why

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F 325	Continued From page 50 Resident 5 would not get her supplements as ordered. RD E stated that she would want the supplements standardized. RD E stated that she uses the information on the MAR for her assessments. RD E stated that the CNAs document the intake and there is a verbal communication between the nurse and CNA if the Resident accepted the supplement. Surveyor 27973 spoke with Director of Nursing (DON) B on 9/12/12 at 2:30 PM. DON B stated that the supplements go out on the trays and are taken to the resident by the CNAs. DON B stated that at times you do not catch the resident and would then later reproach or try to give the supplement at the next meal. DON B stated that staff should provide assistance if needed and that Resident 5's care plan should include the snack of choice intervention.	F 325		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Surveyor: 22597 Based on observation and interview the facility did not ensure each resident received food that was palatable for 3 supplemental residents (Residents 17, 18 and 19) from a census of 71.	F 364		

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F 364	Continued From page 51 The facility's toast was not palatable and the crust was too hard to eat for Residents 17, 18, and 19. This is evidenced by the following: During the group interview on 9/11/12 at 10:30 AM, Resident 17 and Resident 18 stated the crust of the toast is so hard you can't eat it. Resident 19 stated you can't bite the toast. Resident 18 stated she has told dietary staff about the hard crust before. On 9/12/12, at 8:50 AM, after the final plate was served Surveyor 22597 tasted the toast. The center of the toast was rubbery and unable to bite through it. The crust was very hard and Surveyor 22597 could not break it up. Dietary Manager (DM) D was present at the time and stated she was not aware of resident concerns with the toast. DM D stated she could see the crust on the piece Surveyor 22597 was hard. Surveyor 22597 found the toast to be unpalatable.	F 364		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		

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F 425	Continued From page 52 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 29094 Based on record review and interview in 1 of 15 total residents reviewed (Resident 1), the facility did not provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's) to meet the needs of each resident. Resident 1 was to receive the long acting pain medication Fentanyl 50 mcg every 72 hours. Resident 1 did not get his schedule Fentanyl Patch at the scheduled time. This is evidence by: The facility policy titled "medication Administration", dated 1/01 and revised 4/05, states... The Licensed Nurses... will administer medication according to state specific regulation. the Licensed nurse... will check the following to administer medication:... Right medication, right dose,.. right time... "Note it is not acceptable to write "NA" for medication not available from pharmacy. Remove a dose from Back-up supply/Emergency kit or contact pharmacy or	F 425		

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on-call pharmacist and request medication be sent ASAP (as soon as possible). If the medication is not available, contact the Physician for further orders.

The facility policy titled Resident directed care initiative related to Medication Pass, Undated,... daily 6:30 AM - 10 AM - listed as AM on MAR... Physician orders with scheduled times will be given as ordered according to standard of practice.

Duragesic Fentanyl Transdermal system; Janssen Pharmaceuticals: Initial United States approval: 1968.. revised 7/2012 states the following; Highlight of prescribing information: Dosage and administration... Each transdermal system is intended to be worn for 72 hours.... (2.4) Administration of Duragesic:... Each Duragesic patch may be worn continuously for 72 hours. The next patch is applied to a different skin site after removal of the previous transdermal patch... (12.3) Pharmacokinectics: Absorption... With continuous use, serum Fentanyl concentrations continue to rise for the first 2 system applications. By the end of the second 72-hour application, a steady-state serum concentration is reached and is maintained during subsequent application of a patch of the same size...

Resident 1 was admitted to the facility on 11/24/07 with the following diagnoses; Pyogen Arthritis, Osteoarthritis, Schizophrenia, depression...

Resident 1's Physician order sheet, dated 9/12, indicates Fentanyl 50 microgram (mcg) (A strong

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prescription pain medicine that contains an opioid (narcotic) that is used to treat moderate to severe around the clock pain.) per hour apply 1 patch topically to skin and change every 72 hours...

Resident 1's medication administration record (MAR), dated 9/11/12, indicates Resident 1 is to receive Fentanyl 50 mcg per hour apply 1 patch topically to skin and change every 72 hours... Resident 11's MAR also states Resident 11 is to receive the Fentanyl Patch at "AM" (Indicating the pain medication patch was to be given between 6:30 AM and 10:00 AM)

On 9/11/12, at 8:30 AM Surveyor 29094 spoke with Licensed Practical Nurse (LPN) N regarding residents needing to have topically patches applied today. LPN N stated Resident 1 has Fentanyl patch to be re-applied this morning. LPN N continued to state Resident 1 does not have a current prescription at the pharmacy to allow us to reapply his narcotic Fentanyl patch. LPN N stated she would notify Surveyor 29094 when Resident 1's Fentanyl patch was available to be applied to Resident 1.

On 9/11/12, at 10:30 AM LPN N approached Surveyor 29094 and stated she was still waiting for Pharmacy to contact Resident 1's Physician to obtain a Prescription for the Fentanyl narcotic pain patch. LPN N continued to state she had to have an authorization number prior to replacing Resident 1 his Fentanyl narcotic pain patch.

On 9/11/12, at 11:30 AM LPN N approached Surveyor 29094 and stated she was again still waiting for Pharmacy to contact Resident 1 Physician to obtain a prescription for the Fentanyl

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narcotic pain patch. LPN N stated she spoke with the Pharmacy and the Pharmacy is still waiting to receive the prescription from Resident 1's Physician. LPN N stated no she has not called Resident 1's Physician the Pharmacy calls the Physicians.

On 9/11/12, at 1:30 PM LPN N approached Surveyor 29094 and stated she was going to call Resident 1's Physician to try to get the prescription pushed through. LPN N stated she has not received authorization to replace Resident 1 Fentanyl narcotic pain patch. LPN N stated Resident 1 has not received his Fentanyl pain patch today. LPN N also stated Resident 1 last Fentanyl patch was placed on 9/8/12, 72 hours prior to the patch to be placed. LPN N stated the patch is put on in the morning usually before 8 AM.

On 9/11/12, at 2:30 PM LPN N approached Surveyor 29094 and stated she received the prescription from the Physician and faxed the prescription to Pharmacy. LPN N also stated she was waiting for the Pharmacy to fax the authorization number to the facility. LPN N stated Resident 1 has not received his replacement Fentanyl narcotic pain patch.

Resident 1's Pharmacy authorization form, dated 9/11/12, and time stamped as faxed to the facility at 15:22 military time (3:22 PM).The Authorization form states Resident 1 Fentanyl 50 mcg patch, authorization number listed on the form, quantity 1 patch.

On 9/12/12, at 4:30 PM, Surveyor 29094 spoke with Director of Nursing (DON) B regarding the

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F 425	Continued From page 56 facility protocol in re-filling narcotic medications. DON Stated the nurse is to call the Physician and request a prescription to be sent to the pharmacy and the Pharmacy then will fax the authorization to the facility. DON B also stated if the nurse does not get a response from the Physician then the Nurse is to call the Medical Director for the prescription. DON B stated the pharmacy does not call the Physician it is the responsibility of the nurse to call the Physician. DON B also stated she was unaware Resident 1 did not receive his Fentanyl patch at his scheduled time on 9/11/12. On 9/12/12, at 6:10 PM, Surveyor 29094 spoke with LPN O regarding Resident 1's Fentanyl 50 mcg narcotic pain patch. Surveyor 29094 asked LPN O what time she replaced Resident 1's pain medication patch. LPN O stated she replaced the Fentanyl pain patch at 6:30 PM yesterday evening. (3 hours after the authorization number was available for Resident 1 to receive his scheduled narcotic pain medication.) LPN O also stated she remove the Fentanyl patch from the facility contingency back up box to apply to Resident 1. Resident 1 received his Fentanyl patch approximately 10 hours after Resident 1's Fentanyl patch was scheduled to be applied, and 82 hours after the previous Fentanyl Patch was applied.	F 425		
F 441 SS=E	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	F 441		

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F 441	Continued From page 57 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. (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: Surveyor: 29094 Based on observation and interview the facility	F 441		

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did not ensure staff wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice for 2 (Residents 9, and 11) of 13 residents observed for direct care, staff providing cares did not wash hands when removing contaminated gloves as indicated by accepted professional practice.

The facility failed to 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. This has the potential to affect residents on the Deer Path hall and Woodside Terrace hall.

The Certified Nursing Assistant (CNA) K did not wash her hands between glove changes while doing cares with Resident 9.

The Certified Nursing Assistant (CNA) C performed peri rectal care prior to performing perineal care without washing her hands or changing her glove changes, while doing cares with Resident 9.

The Certified Nursing Assistant (CNA) L did not change her gloves or wash her hands between glove changes while doing cares with Resident 11.

The medication cart used for the Deer Path hallway has crusted debris along the full length of each drawer handle and spatter on the bottom of the medication cart. Drawer 1 is extremely unsanitary, with dirt particles and debris throughout and a dried unidentifiable object on top of the alcohol wipes.

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The treatment cart used for the Woodside Terrace hall is unsanitary. The plastic containers containing treatment supplies are visibly soiled and there is debris throughout drawer 1.

This is evidence by:

The facility policy titled "Hand Hygiene", dated 4/99 and revised 11/2011: Hand hygiene is the most important procedure for preventing Healthcare associated Infections... A Plain soap and water or an alcohol hand rub may also be used: 2. Before direct contact with residents... 4. After contact with resident's intact skin... 6. During resident cares if moving from a contaminated body site to a clean body site. 7. After contact with inanimate objects... in the immediate vicinity of the resident. 8. After removing gloves...

The facility policy titled "Guidelines for providing perineal care", undated, states... 4. Follow standard precautions when providing perineal care. 6. Cleanse the woman's vulva... before the peri-rectal area is cleansed.. 9. Remove your gloves and wash your hands before touching clean clothing, linens or the resident.

On 9/12/12, at 4: 45 PM, Surveyor 29094 spoke with Director of Nursing (DON) B regarding the facility expectation of infection prevention. DON B stated she would expect hands to be washed before and after glove removal. DON B also stated she would expect facility staff to remove their gloves after doing incontinent perineal care and prior to touching clean items in any resident rooms.

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F 441	Continued From page 60 Example 1 On 9/10/12, at 1:25 PM, Surveyor 29094 observed Certified Nursing Assistant (CNA) K Resident 9 was lying on the bed. CNA K applied gloves and unfastened and pulled down the front of Resident 9's soiled incontinent brief. Resident 9's incontinent brief was soiled with urine and smeared with bowel movement. CNA K cleansed Resident 9's perineal area with disposable wipes and perineal wash. CNA K rolled Resident 9 onto her side and performed Bowel movement incontinent care. CNA K removed Resident 9's soiled incontinent brief and disposed of the brief in the garbage. CNA K using the same gloves reached into Resident 9's bedside dresser drawer and removed another dry disposable wipe and wiped Resident 9's buttock. CNA K using the same gloves applied a new brief to Resident 9 under Resident 9. CNA K reached a second time into Resident 9's bedside dresser drawer and removed a tube of protective ointment. CNA K squeezed the protective ointment onto her soiled gloves and applied the protective ointment to Resident 9's perineal area. CNA K applied Resident 9's new brief and fastened the brief around Resident 9. CNA K removed her soiled gloves. CNA K covered Resident 9 with a sheet and blanket. CNA K touched Resident 9's bed control and raised Resident 9's head of the bed. CNA K then placed Resident 9's call light on Resident 9's cover and attached a clip to Resident 9's covers. CNA K lowered Resident 9's bed to the low position and placed floor mats on both sides of Resident 9's bed. CNA K removed the gait belt from Resident 9's bedside table and placed the gait belt around CNA K's waist. CNA K removed the soiled linen in a bag from the	F 441		

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garbage can. CNA K placed the garbage bag on the floor by the bathroom door and entered the bathroom and washed her hands.

Example 2
On 9/12/12, at 9:35 AM Surveyor 29094 observed Certified Nursing Assistant (CNA) C and CNA M transfer Resident 9 to her bed. CNA C removed Resident 9's adult brief and provided peri rectal care to Resident 9. CNA C cleansed Resident 9's rectal area with disposable wipe sprayed with perineal wash. CNA C removed smeared Bowel movement (BM) from Resident 9's peri rectal area. CNA C using the same gloves with observed BM on the right thumb of CNA C's glove rolled Resident 9 onto her back and provided front perineal care to Resident 9. CNA C removed her gloves and washed her hands. CNA C cleansed Resident 9's peri rectal area prior to cleansing Resident 9's perineal area while wearing the same contaminated gloves.

On 9/12/12, at 4:45 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding providing perineal care and glove changing. DON B stated she would expect front perineal care to always be completed prior to doing peri rectal care. DON B also stated she would have expected CNA C to change her gloves and wash her hands after doing peri rectal care and prior to performing perineal care.

Example 3
On 9/12/12, at 2:30 PM Surveyor 29094 observed CNA L removed Resident 11's urine soiled adult brief and provide perineal care. Resident 11's adult brief was heavily soiled with strong odorous urine. CNA L with a wet wash cloth provided

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perineal care to Resident 11. Resident 11's scrotum was bright red in color with a wrinkled maceration appearance. Resident 11 also was observed to have an approximately a 0.4 centimeter round dark red blister appearance area in the center of Resident 11's pubis area. CNA L cleanse Resident 11's scrotum area with the wet wash cloth. CNA L using the same gloves placed a clean new brief alongside of Resident 11 and rolled Resident 11 onto his left side. CNA L provided peri rectal care to Resident 11. CNA L using the same gloves removed a tube of protective ointment from Resident 11's bedside table and applied the protective ointment to Resident 11's perineal and peri rectal area. CNA L using the same gloves placed the clean brief under Resident 11 and fastened the clean adult brief in place. CNA L removed her gloves and washed her hands.

On 9/12/12, at 3:28 PM Surveyor 29094 spoke with Director of Nursing (DON) B regarding handwashing expectations. DON B stated gloves should be removed and hands should be washed after performing perineal care. New gloves should be applied before touching any other object in the room or applying ointments or new adult briefs.

Example 4
On 9/11/12 at 8:37 AM, Surveyor 30992 observed a medication cart in the Deer Path hallway outside of room 113. The medication cart has crusted debris along the full length of each drawer handle and spatter on the bottom of the medication cart. Drawer 1 is extremely unsanitary, with dirt particles, debris and adhesive left from tape, throughout the drawer, as well as a dried one inch unidentifiable object on top of the

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F 441	Continued From page 63 alcohol wipes. On 9/11/12 at 8:38 AM, Surveyor 30992 interviewed RN U. RN U stated the medication cart is dirty and she is not aware of a cleaning schedule for the medication cart. Example 5 On 9/12/12 at 9:05 AM, Surveyor 30992 observed a treatment cart in the medication room for the Woodside Terrace hall. The treatment cart is cart used for the Woodside Terrace hall is unsanitary. The plastic containers containing treatment supplies are visibly soiled and there is debris throughout drawer 1. On 9/12/12 at 9:08 AM, Surveyor 30992 interviewed RN T. RN T stated the cart is not clean. On 9/11/12 at 10:17 AM, Surveyor 30992 interviewed DON B. DON B stated there is no formal policy or regular cleaning schedule for the medication carts. DON B stated the night shift is to clean the carts as needed and Omnicare Pharmacy comes in once a month and will point out if the carts need to be cleaned. DON B stated the Omnicare representative was here two days ago and said there was spatter on the bottom of the cart, but did not mention anything else. DON B stated she will institute a regular cleaning schedule for all medication carts. On 9/12/12 DON B stated the treatment carts have been added to the cleaning schedule as well.	F 441		
F 456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456		

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F 456	Continued From page 64 mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Surveyor: 22597 Based on observation and interview the facility did not provide maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This could affect all 71 residents. The knobs on the ovens were missing thus staff were not able to determine the proper temperature the ovens were set at. The ovens are used to heat the facility's pellet system (used to keep plates of food warm). This is evidenced by the following: On 9/11/12, at 8:53 AM, Surveyor 22597 observed Cook F preparing resident meals. Cook F, with an oven mitt, took a metal plate for the pellet system out of the oven and then placed a plate on top of the metal plate. The metal plate was exposed. Surveyor 22597 interviewed Cook F about the temperature of the pellets. Cook F stated the oven is between 180-200 degrees. Surveyor 22597 noted the knobs on the 2 ovens were missing and Surveyor 22597 could not tell what temperature the ovens were set at. Cook F stated the knobs have always been missing and she estimates the temperature. Cook F continued to state the ovens are only used to heat up the pellets and not to cook food.	F 456		

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F 456	Continued From page 65 On 9/11/12, at 2:05 PM, Surveyor 22597 interviewed Dietary Manager (DM) D. DM D stated the pellets are heated up in the oven. Surveyor 22597 asked DM D how staff knows what temperature the ovens are set at. DM D stated they guess by turning the knob. DM D stated she would have to have maintenance order new knobs and DM D agreed the ovens were not in proper working order. Surveyor 22597 also noted there was not a thermometer in the ovens to help identify the temperature.	F 456		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 29094 Based on observation, interview and record review, the facility did not maintain clinical records in accordance with accepted professional standards and practices. Records were not complete and accurately documented for 1	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525616	A. BUILDING _____ B. WING _____	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYVILLE NUR REHAB CTR	305 S CLARK ST MAYVILLE, WI 53050

(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 514	Continued From page 66	F 514		

(Resident 21) of 21 sampled and supplemental residents.

Resident 21's Physician Order Sheet (POS), signed by the Physician on 9/12, showed three medications ordered for bedtime that were not administered at bedtime. The signed Physician Orders did not match the administration times noted in the MAR (Medication Administration Record) and did not accurately reflect the actual medication administration times for three medications.

This is evidenced by:

Example 1
The facility policy titled Resident directed care initiative related to Medication Pass, Undated,... PM 3:30 PM - 7 PM - listed as PM on MAR (Medication administration record)... HS (bedtime) 8 PM - 11 PM - listed as hs on the MAR Physician orders with scheduled times will be given as ordered according to standard of practice.

On 9/10/12 at 3:30 PM AM, Surveyor 29094 observed Licensed Practical Nurse (LPN) O administer medications during the PM Medication Pass. LPN O administered 5 Medications to Resident 21--Aspirin 325 milligrams (mg), Tylenol 325 mg 2 tablets, Famotidine 20 mg, Metoprolol 25 mg, and Simvastatin 20. A review of Resident 21's Physician Order Sheet (POS) verified that these medications were administered correctly as ordered.

Resident 21's POS, signed by the Physician on 9/12, noted three of the medications were to be

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F 514	Continued From page 67	F 514		

administered at bedtime--Aspirin 325 milligrams (mg), Famotidine 20 mg, and Simvastatin 20. These changes to give on PM had been noted in the MAR, but the valid Physician Orders, signed 9/12, ordered the medications to be administered at bedtime. There is no Physician Order to change administration time from bedtime to 3:30 PM.

On 9/12/12 at 8:45 AM, Surveyor 29094 interviewed Director of Nursing (DON) B concerning the medication administration times. DON B stated that the medication administration times on each Resident's Physician Order Sheet should match the times administered in the MAR for each Medication. DON B stated the timing should have been caught by the nurses checking the medication at the end of each month. DON B stated the Pharmacy placed PM on the MAR and no one updated the original order from bedtime. DON B stated that if an administration time is changed it should be updated on both the POS and the MAR. DON B stated that the facility would be doing a chart audit for all Residents to make sure that the Physician orders match the actual administration times in the MAR for all medications.