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	525360	A. BUILDING _____ B. WING _____	08/21/2018

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F 000	INITIAL COMMENTS This was a recertification and extended survey conducted at Bethel Center - Arpin from 8/13/18 through 8/21/18. Number of federal citations issued: 10 Most serious citations is F812 cited at severity/scope of K (immediate jeopardy/pattern). Census: 40 Sample Size: 19 Supplemental: 2	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/05/2018

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that the physician was notified of a change in condition on 1 of 19 residents (R3) reviewed. R3 had a change in condition on 4/14/18 and physician was not notified of this change in condition until 4/17/18, when he required hospitalization. Evidenced by:	F 580		

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The facility's policy "Change in a Resident's Condition or Status," copy right dated 2001 Med-Pass Inc, with revised date December 2016, includes, in part: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an):...d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly...2. A "significant change" of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not "self-limiting")...

R3 diagnoses include: Atrial fibrillation, Dextrocardia, Hypertension, Type 2 Diabetes Mellitus, Morbid Obesity.

On 8/16/18 at 9:26 AM, Surveyor reviewed medical record. Surveyor noted that on 4/12/18 R3 was having issues with breathing and needed oxygen (O2). Nurse Practitioner (NP) did evaluate resident on that date. On 4/14/18, R3 was noted to have cough and green sputum. This was a change in R3's medical condition. R3 did not have any mention of colored sputum in previous notes. No physician notification was made. On 4/15/18, R3 was coughing with small amount of light green sputum noted. No physician notified. On 4/16/18, R3 has productive cough with green colored phlegm noted. No physician notification. Also, on 4/16/18, R3 was noted to have drops in oxygen levels to mid-80's and required a mask instead of nasal cannula for oxygen administration. No physician was notified. On 4/17/18, resident was evaluated by NP and it was decided to send him to ER (Emergency Room)

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F 580	Continued From page 3 for evaluation where he was admitted for pneumonia. On 8/16/18 at 8:41 AM, Surveyor interviewed DON B (Director of Nursing) regarding R3's change in condition and MD not being notified, which ended up with R3 being hospitalized. Surveyor and DON B reviewed the Nurse's Notes from 4/12/18 to 4/17/18; discussed 4/14/18 where nurse documents that resident had coughing with green sputum. Surveyor asked DON B if this was a change in R3's condition and she said "Yes." Surveyor asked DON B if she would expect her nurse to update the MD and DON B said "Yes." Discussed the 4/15/18 notes and if MD should have been updated on R3's continued cough with small amount of sputum light green in color. DON B said MD should have been updated. Discussed the 4/16/18 notes where productive cough with green colored phlegm was noted. DON B stated physician should have been updated. DON B stated that she would have expected her nurse to have updated physician on R3's change in condition. DON B thought that R3's hospitalization may have been avoided if MD had been updated earlier and potentially started on antibiotic earlier.	F 580		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		

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F 625	Continued From page 4 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure bedhold notices were given in writing before transfer for 5 of 5 residents (R18, R3, R21, R42, R30) reviewed for transfer to hospital. R18 was admitted to hospital on 7/17/18 and no bedhold notice was given to resident or representative. R3 was admitted to hospital on 4/17/18 and no bedhold notice was given to resident or representative. R21, R30, and R42 did not receive notice of bedhold prior to going to the hospital.	F 625		

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F 625	Continued From page 5 Evidenced by: The facility did not have an actual bedhold policy. The facility presented a sheet entitled "Bedhold Information," (which does not have a date on it) which they present to residents on admission. This informational sheet is the only thing they have been completing upon admission in regards to bedhold. No written bedhold notice is given upon transfer of a resident to hospital. Example 1 R18 was transferred to hospital where he was admitted on 7/17/18. No written bedhold notice was presented to resident or resident representative. On 8/15/18 at 2:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked if R18 or resident representative received a bedhold written notice. DON B stated that residents receive notice about bedhold when they are admitted. Surveyor asked if residents receive written bedhold notices upon transfer to the hospital from NH (Nursing Home). DON B stated that they do not give any written notice of bedhold to residents before transfer to hospital. Example 2 R3 was transferred to hospital where he was admitted on 4/17/18. No written bedhold notice was presented to resident or resident representative. On 8/16/18 at 8:41 AM, Surveyor interviewed DON B regarding R3's hospitalization and bedhold written notice being given. DON B stated that R3 didn't receive a written bedhold either and that they are working on this.	F 625		

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F 625	Continued From page 6 Example 3 R21 was admitted to the facility on 1/3/18. On 1/23/18, 2/12/18 and 7/19/18, R21 was transferred from the facility to the hospital. There was no evidence in R21's medical record that she received a copy of the facility bedhold policy or charges that could accrue. Example 4 R30 was admitted to the facility on 11/18/17. On 11/13/17 and 2/7/18, R30 was transferred from the facility to the hospital. There was no evidence in R30's medical record that she received a copy of the facility bedhold policy or charges that could accrue. Example 5 R42 was admitted to the facility on 7/3/17. On 7/22/17, 10/30/17, 12/30/17, 1/22/18, 2/11/18, 3/2/18, 4/25/18, and 5/21/18, R42 was transferred from the facility to the hospital. There was no evidence in R42's medical record that he received a copy of the facility bedhold policy or charges that could accrue.	F 625		
F 655 SS=J	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		

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(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not develop a Baseline Care Plan (developed within 48 hours of admission) that provides instructions for effective and person-centered care that identifies conditions and risks affecting resident health and safety for 1 out of 4 residents

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(R190) that are at risk for wandering from a total sample of 40.

Although the facility had assessed R190 as being at "above high" risk for wandering, the facility did not develop and share a Baseline Care Plan to address R190's wandering risk when he was admitted to the facility. Staff did not know R190 was a wandering risk and did not have interventions in place to minimize the risk for wandering.

The facility's failure to develop a Baseline Wandering Care Plan and to ensure staff were informed and educated, regarding R190's high risk for wandering, prevented adequate supervision and created a finding of Immediate Jeopardy (IJ). The IJ began on 8/10/18. NHA A (Nursing Home Administrator) was officially notified of the IJ on 8/16/18 at 1:00 PM. The facility removed the IJ on 8/16/18. However, the deficient practice continues at a scope/severity level D (potential for harm that is not immediate jeopardy/isolated) as the facility continues to implement its removal plan.

This is evidenced by:

R190 was admitted to the facility on 8/8/18. His admitting diagnoses are glioblastoma (malignant brain tumor) and anxiety.

R190's Hospital Discharge Summary, dated 8/7/18, documented he has left (L) arm and left leg weakness, with a left visual cut.

The facility had not completed a Brief Interview for Mental Status (BIMS), but documented he has some cognitive loss.

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On 8/8/18, the facility assessed R190 on the Wandering Risk Assessment as being ambulatory and scoring an 11. An 11 score is "Above High Risk to Wander." LPN I (Licensed Practical Nurse) documented on the assessment, "Resident was confused in his room this evening. Trying to find his room on another hall."

On 8/16/18 at 1:00 PM, Surveyor spoke with MDS Coord N (Minimum Data Set Coordinator). MDS Coord N said no Initial Care Plan had been created for R190's wandering/elopement risk.

On 8/9/18, the facility assessed R190 on the Smoking-Safety Screen. R190 scored a 2, which is indicated as safe to smoke with supervision, with smoking materials kept in the medication room.

R190's care plan, dated 8/9/18, documents that he is a high risk for falls due to a progressive symptomatic brain mass affecting his left visual field, along with frequent falls at home and dizzy spells.

On 8/16/18 at 12:30 PM, Surveyors observed R190 across a road, sitting on his four wheeled walker. When Surveyors approached R190, he was smoking a cigarette. When Surveyors asked him what he was doing, he said he was having a peaceful smoke on this beautiful day. When Surveyors asked him which way he would return to the nursing home, R190 pointed in the opposite direction of the nursing home and said, "I'll be heading home that way."

Surveyors informed facility staff of R190's status outside and staff redirected R190 to the nursing

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home. The facility staff was not aware that R190 had left the building unescorted and was smoking outside without supervision.

On 8/16/18 at 1:21 PM, Surveyor spoke with R190. R190 said, "I go out by myself at times--I go out the back door-around the corner-I just push on the door a little and wait a minute and it opens. But sometimes I just go out front and walk around."

On 8/16/18 at 1:30 PM, Surveyor spoke with HSKR M (Housekeeper). HSKR M said, "No, I haven't seen him go out by himself, and I didn't know he was a high wander risk."

On 8/16/18 at 1:33 PM, Surveyor spoke with CNA K (Certified Nurse Assistant). CNA K said she did not see R190 go out by himself and she did not know he was a high wandering risk.

On 8/16/18 at 1:35 PM, Surveyor spoke with DON B (Director of Nursing) and NHA A (Nursing Home Administrator). NHA A and DON B said they did not know that R190 had wandered outside and was smoking by himself. Surveyor asked the NHA A and DON B when the Wander Assessments are done, where does it go and who follows up on it? DON B said, "We open the computer form in Point Click Care (PCC-electronic medical record) and in Stand-Up Meeting the day after a new admission. If it is scored high risk, we put it in the care plan and put a WanderGuard on the resident if we feel they are going to elope." Surveyor asked, "Since R190 scored high wandering risk at an 11, why was no WanderGuard put on him?" DON A said, "Well, when he first got here he was very weak and couldn't get in his wheelchair by himself, so we

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thought he would not wander, even though he scored high on the Wander Assessment. We did not reassess him when he got strong enough to walk with his walker."

The facility's failure to develop a Wander Care Plan to prevent R190 from wandering outside created a finding of IJ.

The facility removed the IJ on 8/16/18 by implementing the following interventions:

* Nursing Staff will be educated regarding the risk assessment and what the score means, what to do (i.e. put in place interventions/supervision) when a resident is at high risk or a wanderer, education on care planning for those at risk or who are wanderers and what to do with the care plan interventions has been conducted with all nurses on duty on 8/16/18 by the DON or her designee. Additionally, education will be conducted with all oncoming nurses prior to beginning their next shift. Nurses will be responsible to monitor smoking materials, and ensure they are returned. Nurses on duty have been educated as to this responsibility and oncoming nurses will be educated prior to the beginning of the next shift. Education will be completed by all active staff by 9/14/18 all staff who are prn or on leave will have their education completed before their next scheduled shift.

* All staff will be educated on knowing what high risk of wandering means, knowing who is at risk for wandering or who is a wanderer, who is on the wandering list, location of the of the elopement risk book, and the policy and procedure regarding wandering. They will also be educated on the smoking policy, where smoking materials are to

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be kept, to know who is a smoker and safe to have smoking materials and what supervision means. Department heads or designees will educate all staff on duty and prior to their next scheduled shift. Education will be completed by all active staff by 9/14/18 all staff who are prn (as needed) or on leave will have their education completed before their next scheduled shift.

* All of the above education will be included in orientation of new hires and for Agency Personnel.

* Resident has been re-educated on 8/16/18 by the DON that he may not leave the building nor smoke without supervision. At the same time, he also was instructed that he may not possess smoking materials or retain them after a smoking session. All smoking materials are to be returned to the nurse at the conclusion of a smoking session. The resident has a WanderGuard in place and it is Care Planned. WanderGuard will be checked for placement and function every shift.

Monitoring

* The smoking resident's room will be checked by DON or her designee daily for 7 days for the presence of smoking materials. If none located will be checked twice weekly to verify that the resident has not obtained smoking materials.

* The DON or her designee will conduct audits on wandering and elopement assessments and care plans weekly for 6 weeks.
If no further issues identified, monitoring will be completed monthly as part of the Quality Improvement program for the next 6 months.

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Findings of the audits will be communicated to the QAPI Based on interview and record review, the facility did not ensure that each resident receives adequate supervision to prevent accidents for 1 of 4 residents (R190) reviewed for wandering. 1 of 1 resident reviewed for smoking (R190) and 3 of 4 residents (R3, R5, R10) reviewed with electric wheelchair charging.

Although the facility had assessed R190 as being at above high risk for wandering, the facility did not develop a Wandering Care Plan, educate staff of R190's high risk for wandering, or implement measures to minimize the risk that R190 would leave the facility without staff knowledge or supervision, as occurred on 8/16/18. Additionally, R190 was assessed to require supervision with smoking. R190 was observed to be smoking without supervision.

R3, R5 and R10 had electric wheelchairs charging in their rooms.

Failure to ensure systems were in place to prevent R190 from wandering created a finding of Immediate Jeopardy (IJ). The IJ began on 8/16/18. NHA A (Nursing Home Administrator) was officially notified of the IJ on 8/16/18 at 1:00 PM. The facility removed the IJ on 8/16/18. However, the deficient practice continues at a scope/severity level D (potential for harm that is not IJ/isolated) as the facility continues to implement its removal plan.

This is evidenced by:

Example 1
R190 was admitted to the facility on 8/8/18. His admitting diagnoses are glioblastoma (malignant

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brain tumor) and anxiety.

R190's Hospital Discharge Summary, dated 8/7/18, documented he has left arm and left leg weakness, with a left visual cut.

The facility had not completed a Brief Interview of Mental Status (BIMS), but documented he has some cognitive loss.

On 8/8/18, the facility assessed R190 on the Wandering Risk Assessment as being ambulatory and scoring an 11. An 11 score is "Above High Risk to Wander." LPN I (Licensed Practical Nurse) narrated on the assessment "Resident was confused in his room this evening. Trying to find his room on another hall." Surveyor spoke with MDS Coord N (Minimum Data Set Coordinator). On 8/16/18 at 1:00 PM, MDS Coord N said no Initial Care Plan was created for wandering/elopement risk.

R190's care plan, dated 8/9/18, documents that he is a high risk for falls due to a progressive symptomatic brain mass affecting his left visual field, along with frequent falls at home and dizzy spells.

On 8/9/18, the facility assessed R190 on the Smoking-Safety Screen. R190 scored a 2, which is indicated as safe to smoke with supervision, with smoking materials kept in medication room.

On 8/16/18 at 12:30 PM, Surveyors observed R190 across a road, sitting on his four wheeled walker. When Surveyors approached R190, he was smoking a cigarette. When Surveyors asked him what he was doing, he said he was having a peaceful smoke on this beautiful day. When

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Surveyors asked him which way he would return to the nursing home, R190 pointed in the opposite direction of the nursing home and said, "I'll be heading home that way."

R190 had walked approximately 25 yards from the building to the road. He then crossed the road and walked another 20 yards, across uneven terrain, to sit in private property of the neighboring property. Surveyors observed approximately 3-8 construction trucks, along with commercial and residential traffic driving on the road each day during the survey.

Surveyors informed facility staff of R190's status outside and staff redirected R190 back into the nursing home.

The facility staff was not aware that R190 had left the building unescorted and was smoking outside without supervision.

On 8/16/18 at 1:00 PM, Surveyor spoke with RN F (Registered Nurse). RN F said, "I gave him a cigarette around 6:45 AM this morning and he must have stashed some--I haven't given any more since then--he gave me everything back and didn't ask to go out since then. I did not know he was assessed as a high wandering risk. No, I didn't know he was out by himself smoking."

On 8/16/18 at 1:21 PM, Surveyor spoke with R190. R190 said, "I go out by myself at times--I go out the back door-around the corner-I just push on the door a little and wait a minute and it opens. But sometimes I just go out front and walk around."

On 8/16/18 at 1:30 PM, Surveyor spoke with

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HSKR M (Housekeeper). Hskr M said, "No, I haven't seen him go out by himself, and I didn't know he was a high wandering risk."

On 8/16/18 at 1:33 PM, Surveyor spoke with CNA (Certified Nurse Assistant). CNA K said she did not see R190 go out by himself and she did not know he was a high wandering risk.

On 8/16/18 at 1:35 PM, Surveyor spoke with DON B (Director of Nursing) and NHA A. NHA A and DON B said they did not know that R190 had wandered outside and was smoking by himself. Surveyor asked the NHA A and DON B when the wandering assessments are done, where does it go and who follows up on it? DON B said we open the computer form in Point Click Care (PCC-electronic medical record) and in Stand Up Meeting the day after a new admission-if it is scored high risk, we put it in the care plan and put a WanderGuard on the resident, if we feel they are going to elope. Surveyor asked, "Since R190 scored as a high wandering risk at an 11, why was no WanderGuard put on him?" DON B said, "Well, when he first got here he was very weak and couldn't get in his wheelchair by himself, so we thought he would not wander, even though he scored high on the Wander Assessment. We did not reassess him when he got strong enough to walk with his walker."

While R190 has some cognitive loss, he was able to communicate at least two ways to leave the nursing home unobserved. R190 Smoking Assessment noted he smokes at least one half pack of cigarettes a day and was very strongly motivated to go outside to smoke. Since R190 was cognitively impaired with his brain tumor, he did get confused at times and needed supervision

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F 655	Continued From page 17 for his safety. Failure to provide / develop a care plan to address R190's risk for wandering, failure to communicate this risk to staff, and failure to implement measures to prevent R190 from leaving the facility unsupervised and without staff knowledge created a finding of IJ. The facility removed the IJ on 8/16/18 by implementing these following interventions: * Nursing Staff will be educated regarding the risk assessment and what the score means, what to do (i.e. put in place interventions/supervision) when a resident is at high risk or a wanderer, education on care planning for those at risk or who are wanderers and what to do with the care plan interventions has been conducted with all nurses on duty on 8/16/18 by the DON or her designee. Additionally, education will be conducted with all oncoming nurses prior to beginning their next shift. Nurses will be responsible to monitor smoking materials, and ensure they are returned. Nurses on duty have been educated as to this responsibility and oncoming nurses will be educated prior to the beginning of the next shift. Education will be completed by all active staff by 9/14/18 all staff who are prn or on leave will have their education completed before their next scheduled shift. * All staff will be educated on knowing what high risk of wandering means, knowing who is at risk for wandering or who is a wanderer, who is on the wandering list, location of the of the elopement risk book, and the policy and procedure regarding wandering. They will also be educated on the smoking policy, where smoking materials are to be kept, to know who is a smoker and safe to	F 655		

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have smoking materials and what supervision means. Department heads or designees will educate all staff on duty and prior to their next scheduled shift. Education will be completed by all active staff by 9/14/18 all staff who are prn or on leave will have their education completed before their next scheduled shift.

* All of the above education will be included in orientation of new hires and for Agency Personnel.

* Resident has been re-educated on 8/16/18 by the DON that he may not leave the building nor smoke without supervision. At the same time, he also was instructed that he may not possess smoking materials or retain them after a smoking session. All smoking materials are to be returned to the nurse at the conclusion of a smoking session. The resident has a WanderGuard in place and it is Care Planned. WanderGuard will be checked for placement and function every shift.

Monitoring

* The smoking resident's room will be checked by DON or her designee daily for 7 days for the presence of smoking materials. If none located will be checked twice weekly to verify that the resident has not obtained smoking materials.

* The DON or her designee will conduct audits on wandering and elopement assessments and care plans weekly for 6 weeks.
If no further issues identified, monitoring will be completed monthly as part of the Quality Improvement program for the next 6 months.
Findings of the audits will be communicated to

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F 655	Continued From page 19 the QAPI (Quality Assurance and Performance Improvement) Committee monthly for review and action indicated by observations. Date of completion 8/16/18.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 657		

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did not ensure that the Comprehensive Care Plan was developed and revised for 2 of 19 residents (R29 and R26) reviewed.

R29's care plan was not revised after he was determined to have a new skin condition.

R26's medical record indicated she had an open area on her coccyx. R26's Comprehensive Care Plan did not address the open area on R26's coccyx.

Evidenced by:
R29's diagnoses include: Chronic diastolic (congestive) heart failure, encounter for palliative care, shortness of breath, atrial fibrillation, Type 1 Diabetes Mellitus.

On 8/16/18 at 10:00 AM, Surveyor reviewed medical record and found documentation that, on 8/11/18 at 9:56 PM, LPN I (Licensed Practical Nurse) completed a Providence Skin Observation Tool (Licensed Nurse) which was an initial evaluation of skin condition/open area on the coccyx. There was no revision to R29's care plan at that time indicating R29 had a new open area or what to do for this open area.

On 8/16/18 at 10:45 AM, Surveyor interviewed DON B (Director of Nursing) about R29's new open area and if this should have been added to his care plan. DON B stated that she would expect her nurse to update the care plan with new changes.

Example 2
R26's diagnoses include: super morbid obesity, history of endometrial cancer, status post

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hysterectomy and chronic hypoxic respiratory failure. R26 is her own decision maker.

R26's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/11/18 indicates that R26 has no pressure, arterial or venous ulcers. It does indicate R26 has a surgical wound.

R26's medical record included the following Progress Notes:
8/10/2018 17:49 - Health Status Note Text: New order to apply Calmoseptine to open area on coccyx BID (twice a day)
8/11/2018 03:27 - Health Status Note Text: resident continues with anti-fungal, rash to abd (abdomen) and open area to bottom remains, no pain or discomfort noted, will continue to monitor
8/12/2018 01:49 - Health Status Note Text: Resident continues to tolerate antbx (antibiotic), and continues with reddened areas to abd, and open area to right buttock, encouraged to reposition self and offload pressure, will continue to monitor.
8/13/2018 02:59 - Health Status Note Text: resident continues on anti-fungal and rash and redness on right buttock, will continue to monitor.
8/15/2018 12:32 - Health Status Note Text: Open area to buttock remains. Tx (treatment) for rash as ordered
8/16/2018 08:13 - Orders - Administration Note Text: Calmoseptine Ointment 0.44-20.6 % Apply to coccyx topically two times a day for open area Okay to use Calazime until resolved

R26's care plan did not address the open area on R26's coccyx.

On 8/16/18 at 4:15 PM, Surveyor interviewed

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F 657	Continued From page 22 DON B. DON B stated she would expect staff to update the care plan with any skin changes. DON B stated R26's care plan should address the open area on her coccyx.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure that the services provided met professional standards. The facility did not have assessments completed by a Registered Nurse (RN) or completed when needed by a RN on 4 of 19 sampled residents (R18, R29, R25, R26). R18 had a fall with head injury and no RN assessment was completed. R29's Providence Wandering Risk Assessment, Providence Braden, and Providence Bedrail Assessment, completed on admission on 7/8/18, were not completed by a RN. R29 did not have a RN assessment after a new skin condition was found. R25's Pain Tool and Morse Fall were completed by a LPN (Licensed Practical Nurse) with no evidence of RN oversight. R26's Skin Risk Observation Tool was completed by an LPN with no evidence of RN oversight.	F 658		

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F 658	Continued From page 23 Evidenced by: The WI Board of Nursing Chapter N 6: STANDARDS OF PRACTICE FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES includes in part: N 6.03 Standards of practice for registered nurses: (1) GENERAL NURSING PROCEDURES. An RN shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation...N 6.04 Standards of practice for LPNs. (1) PERFORMANCE OF ACTS IN BASIC PATIENT SITUATIONS. In the performance of acts in basic patient situations, the LPN shall, under the general supervision of an RN or the direction of a provider: (a) Accept only patient care assignments which the LPN is competent to perform. (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient. (d) Consult with a provider in cases where an LPN knows or should know a delegated act may harm a patient. (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an RN provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs...Manage and direct the nursing care and other activities of LPNs and nursing support personnel under the general supervision of an RN... The facility's policy "Assessing Falls and Their	F 658		

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Causes," with copyright date 2001 Med-Pass. Inc (revised October 2010), includes, in part: After a fall: 1. If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities. 2. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aid. 3. Once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details....

Example 1
R18's diagnoses include: Chronic Obstructive Pulmonary Disease (COPD), Long term (current) use of anticoagulants, Congestive Heart Failure, Hypertension, Atrial Fibrillation, and Type 2 Diabetes Mellitus. R18 has a Brief Interview for Mental Status (BIMS) score of 15.

On 8/14/18 at 2:30 PM, Surveyor reviewed the medical record and found R18 had a fall, on 7/29/18 at 3:00 PM, where he was yelling from the room. LPN R evaluated R18 who stated he hit his head, but did not consult with RN to have a RN assessment completed after this fall with stated head injury. No RN assessment noted until next morning 7/30/18.

On 8/16/18 at 11:32, AM Surveyor interviewed DON B (Director of Nursing) about fall. Surveyor asked DON B if she would expect RN to assess resident after fall with head injury. DON B stated "Yes."

Example 2
R29's diagnoses include: Chronic Diastolic

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(congestive) Heart Failure, encounter for palliative care, Shortness of Breath, Atrial Fibrillation, Type 1 Diabetes Mellitus.

On 8/16/28 at 10:00 AM, Surveyor reviewed medical record. Surveyor found R29's Providence Wandering Risk Assessment, Providence Braden, and Providence Bedrail Assessment completed on admission, on 7/8/18, was completed by LPN I not by a RN. Surveyor also found documentation that, on 8/11/18 at 9:56 PM, LPN I completed Providence Skin Observation Tool (Licensed Nurse), which was an initial evaluation of skin condition/open area on coccyx. On 8/12/18 at 5:31 PM, LPN I completed SBAR (Situation, Background, Assessment and Recommendation) Communication form and Progress Note which addressed the open area on the coccyx. On 8/14/18 at 9:48 PM, LPN I completed Providence Skin Observation Tool (Licensed Nurse) where she indicated there was a pressure area to coccyx. No RN assessment was completed or found in the medical record for this area.

On 8/16/18 at 10:45 AM, Surveyor interviewed DON B and asked where RN weekly assessments were located. DON B said that weekly assessments by RN are done on Weds and she didn't get to them yesterday, with the survey team here. Her usual Wound Nurse is off this week.
On 8/16/18 at 11:34 AM, Surveyor interviewed DON B about RN assessments after finding new pressure area/s. Surveyor asked DON B if she would have a RN do an assessment on a new skin condition especially a pressure injury area and she said "Yes."

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Example 3
R25's diagnoses include dementia, history of stroke and history of falls. R25 is not his own decision maker.

R25's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/9/18 indicates R25 has cognitive impairment, transfers with extensive assistance of two or more people, and has had falls since admission.

R25's Pain Tool, completed 7/2/18, was completed and signed by LPN G. The Pain Tool indicates R25 does not complain of pain when asked and no methods were needed to alleviate pain. (It is important to know there is no evidence of RN oversight or an RN assessment.)

R25's Morse Fall, completed 7/2/18, was completed and signed by LPN G. The Morse Fall indicates is at high risk for falling. (It is important to know there is no evidence of RN oversight or RN assessment.)

On 8/16/18 at 4:15 PM, Surveyor interviewed DON B. DON B stated she could not find any evidence a RN gave oversight to these forms. DON B stated these forms were tools, that an LPN could complete, however, an RN needed to review them so they could be considered the assessment which would need to be completed in these areas. DON B stated these forms should have been co-signed by an RN.

Example 4
R26's diagnoses include: super morbid obesity, history of endometrial cancer, status post hysterectomy and chronic hypoxic respiratory

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F 658	Continued From page 27 failure. R26 is her own decision maker. R26's most recent MDS with an ARD of 7/11/18 indicates that R26 has no pressure, arterial or venous ulcers. It does indicate R26 has a surgical wound. R26's Skin Observation Tool, completed 8/9/18, was completed by LPN S. The Skin Observation Tool indicates R26 has a coccyx wound; it gives measurements and indicates the wound is unstageable. (It is important to know there is no evidence of RN oversight/assessment.) On 8/16/18 at 4:15 PM, Surveyor interviewed DON B. DON B stated she could not find a skin assessment completed by a RN. DON B stated the Skin Observation Tool, completed by LPN S, should have oversight by an RN.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that each resident receives adequate supervision to prevent accidents for 1 of 4 residents (R190) reviewed for wandering. 1 of 1 resident reviewed for smoking (R190) and 3 of 4 residents (R3, R5, R10) reviewed with	F 689		

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electric wheelchair charging.

Although the facility had assessed R190 as being at above high risk for wandering, the facility did not develop a Wandering Care Plan, educate staff of R190's high risk for wandering, or implement measures to minimize the risk that R190 would leave the facility without staff knowledge or supervision, as occurred on 8/16/18. Additionally, R190 was assessed to require supervision with smoking. R190 was observed to be smoking without supervision.

R3, R5 and R10 had electric wheelchairs charging in their rooms.

Failure to ensure systems were in place to prevent R190 from wandering created a finding of Immediate Jeopardy (IJ). The IJ began on 8/16/18. NHA A (Nursing Home Administrator) was officially notified of the IJ on 8/16/18 at 1:00 PM. The facility removed the IJ on 8/16/18. However, the deficient practice continues at a scope/severity level D (potential for harm that is not IJ/isolated) as the facility continues to implement its removal plan.

This is evidenced by:

Example 1
R190 was admitted to the facility on 8/8/18. His admitting diagnoses are glioblastoma (malignant brain tumor) and anxiety.

R190's Hospital Discharge Summary, dated 8/7/18, documented he has left arm and left leg weakness, with a left visual cut.

The facility had not completed a Brief Interview of

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Mental Status (BIMS), but documented he has some cognitive loss.

On 8/8/18, the facility assessed R190 on the Wandering Risk Assessment as being ambulatory and scoring an 11. An 11 score is "Above High Risk to Wander." LPN I (Licensed Practical Nurse) narrated on the assessment "Resident was confused in his room this evening. Trying to find his room on another hall." Surveyor spoke with MDS Coord N (Minimum Data Set Coordinator). On 8/16/18 at 1:00 PM, MDS Coord N said no Initial Care Plan was created for wandering/elopement risk.

R190's care plan, dated 8/9/18, documents that he is a high risk for falls due to a progressive symptomatic brain mass affecting his left visual field, along with frequent falls at home and dizzy spells.

On 8/9/18, the facility assessed R190 on the Smoking-Safety Screen. R190 scored a 2, which is indicated as safe to smoke with supervision, with smoking materials kept in medication room.

On 8/16/18 at 12:30 PM, Surveyors observed R190 across a road, sitting on his four wheeled walker. When Surveyors approached R190, he was smoking a cigarette. When Surveyors asked him what he was doing, he said he was having a peaceful smoke on this beautiful day. When Surveyors asked him which way he would return to the nursing home, R190 pointed in the opposite direction of the nursing home and said, "I'll be heading home that way."

R190 had walked approximately 25 yards from the building to the road. He then crossed the

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road and walked another 20 yards, across uneven terrain, to sit in private property of the neighboring property. Surveyors observed approximately 3-8 construction trucks, along with commercial and residential traffic driving on the road each day during the survey.

Surveyors informed facility staff of R190's status outside and staff redirected R190 back into the nursing home.

The facility staff was not aware that R190 had left the building unescorted and was smoking outside without supervision.

On 8/16/18 at 1:00 PM, Surveyor spoke with RN F (Registered Nurse). RN F said, "I gave him a cigarette around 6:45 AM this morning and he must have stashed some--I haven't given any more since then--he gave me everything back and didn't ask to go out since then. I did not know he was assessed as a high wandering risk. No, I didn't know he was out by himself smoking."

On 8/16/18 at 1:21 PM, Surveyor spoke with R190. R190 said, "I go out by myself at times--I go out the back door-around the corner-I just push on the door a little and wait a minute and it opens. But sometimes I just go out front and walk around."

On 8/16/18 at 1:30 PM, Surveyor spoke with HSKR M (Housekeeper). Hskr M said, "No, I haven't seen him go out by himself, and I didn't know he was a high wandering risk."

On 8/16/18 at 1:33 PM, Surveyor spoke with CNA (Certified Nursing Assistant). CNA K said she did not see R190 go out by himself and she did not

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know he was a high wandering risk.

On 8/16/18 at 1:35 PM, Surveyor spoke with DON B (Director of Nursing) and NHA A. NHA A and DON B said they did not know that R190 had wandered outside and was smoking by himself. Surveyor asked the NHA A and DON B when the wandering assessments are done, where does it go and who follows up on it? DON B said we open the computer form in Point Click Care (PCC-electronic medical record) and in Stand Up Meeting the day after a new admission-if it is scored high risk, we put it in the care plan and put a WanderGuard on the resident, if we feel they are going to elope. Surveyor asked, "Since R190 scored as a high wandering risk at an 11, why was no WanderGuard put on him?" DON B said, "Well, when he first got here he was very weak and couldn't get in his wheelchair by himself, so we thought he would not wander, even though he scored high on the Wander Assessment. We did not reassess him when he got strong enough to walk with his walker."

While R190 has some cognitive loss, he was able to communicate at least two ways to leave the nursing home unobserved. R190 Smoking Assessment noted he smokes at least one half pack of cigarettes a day and was very strongly motivated to go outside to smoke. Since R190 was cognitively impaired with his brain tumor, he did get confused at times and needed supervision for his safety.

Failure to provide / develop a care plan to address R190's risk for wandering, failure to communicate this risk to staff, and failure to implement measures to prevent R190 from leaving the facility unsupervised and without staff

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knowledge created a finding of IJ. The facility removed the IJ on 8/16/18 by implementing these following interventions:

* Nursing Staff will be educated regarding the risk assessment and what the score means, what to do (i.e. put in place interventions/supervision) when a resident is at high risk or a wanderer, education on care planning for those at risk or who are wanderers and what to do with the care plan interventions has been conducted with all nurses on duty on 8/16/18 by the DON or her designee. Additionally, education will be conducted with all oncoming nurses prior to beginning their next shift. Nurses will be responsible to monitor smoking materials, and ensure they are returned. Nurses on duty have been educated as to this responsibility and oncoming nurses will be educated prior to the beginning of the next shift. Education will be completed by all active staff by 9/14/18 all staff who are prn or on leave will have their education completed before their next scheduled shift.

* All staff will be educated on knowing what high risk of wandering means, knowing who is at risk for wandering or who is a wanderer, who is on the wandering list, location of the of the elopement risk book, and the policy and procedure regarding wandering. They will also be educated on the smoking policy, where smoking materials are to be kept, to know who is a smoker and safe to have smoking materials and what supervision means. Department heads or designees will educate all staff on duty and prior to their next scheduled shift. Education will be completed by all active staff by 9/14/18 all staff who are prn or on leave will have their education completed before their next scheduled shift.

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F 689	Continued From page 33 * All of the above education will be included in orientation of new hires and for Agency Personnel. * Resident has been re-educated on 8/16/18 by the DON that he may not leave the building nor smoke without supervision. At the same time, he also was instructed that he may not possess smoking materials or retain them after a smoking session. All smoking materials are to be returned to the nurse at the conclusion of a smoking session. The resident has a WanderGuard in place and it is Care Planned. WanderGuard will be checked for placement and function every shift. Monitoring * The smoking resident's room will be checked by DON or her designee daily for 7 days for the presence of smoking materials. If none located will be checked twice weekly to verify that the resident has not obtained smoking materials. * The DON or her designee will conduct audits on wandering and elopement assessments and care plans weekly for 6 weeks. If no further issues identified, monitoring will be completed monthly as part of the Quality Improvement program for the next 6 months. Findings of the audits will be communicated to the QAPI (Quality Assurance and Performance Improvement) Committee monthly for review and action indicated by observations. Date of completion 8/16/18. The following examples are not at Immediate Jeopardy:	F 689		

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Example 2
The facility's policy entitled "Resident Power Wheelchair Battery Charging Policy," without a date, includes: 1. Chair must never be charged in residents room (this could be a danger to residents during charging period). 2. Chairs can be charged as needed-when not in use. 3. Designated locations: shower room that is not being used at the time. 4. Doors to designated locations must be closed during charging and not used by other residents during this time.

On 8/13/18 at 8:38 PM, Surveyor observed R3 had an electric w/c (wheelchair) plugged in and was charging the battery while he was seated in it. Surveyor had entered room around 8:15 PM. R3 unplugged the w/c as it was done charging. R3 stated that he charges the electric w/c in his room while he is seated in it so he can monitor the charging and as soon as the indicator light turns green then he unplugs it to save on the battery.

On 8/14/18 at 9:08 AM, Surveyor observed R3 had an electric w/c charging in his room. R3 stated he charges the w/c throughout the day in his room. R3 stated he used to charge it overnight, but it doesn't kick off so he charges it during the day now.

On 8/14/18 at 10:35 AM, Surveyor spoke with CNA P about residents with electric w/c's. CNA P stated that there are 4 residents with electric w/c's - R10, R5, R3 and R18, but R18 is not using his at this time. R18's w/c was sitting at the end of the 100 Hall and was not plugged in. CNA P stated that all 3 of the other electric w/c's are charged in the residents rooms.

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F 689	Continued From page 35 On 8/14/18 at 3:25 PM, Surveyor observed R3 charging his w/c in his room. On 8/14/18 at 3:35 PM, Surveyor took DON B to R3's room, but he had disconnected the cord at this time. Surveyor informed DON B that 10 minutes ago it was connected and charging. DON B said that she would have to go around and take the chargers out of the rooms herself. DON B again stated that electric w/c's should not be charged in the resident's rooms. Example 3 On 8/14/18 at 10:40 AM, Surveyor observed R10 sitting in his room in an electric w/c. Surveyor asked R10 if he charges the w/c in his room. R10 stated that he does charge the electric w/c every night in his room and pointed out which plug-in he uses. R3 said the charger is in the closet and it gets pulled out and plugged in beside the closet. On 8/14/18 at 11:14 AM, Surveyor interviewed DON B about the process for charging electric w/c's. DON B stated electric w/c's should be charged in the shower rooms. Surveyor informed her of 2 observations of R3's w/c being charged in his room and that CNA P stated that 3 residents (R3, R5, R10) charge electric w/c's in their rooms. Surveyor also informed DON B of conversations with those residents about charging their electric w/c's in their rooms. Surveyor asked DON B if electric w/c's should be charged in resident's rooms. DON B stated no. DON B stated she will get the policy and start re-education right away. Example 4	F 689		

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F 689	Continued From page 36 On 8/14/18 at 11:07 AM, Surveyor interviewed R5 about electric w/c and charging. R5 stated his electric w/c gets charged in his room about one time per week.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review and facility policy and procedure review, the facility did not develop a Comprehensive Care Plan consistent with professional Standards of Practice for 1 of 1 residents reviewed for dialysis care (R27) out of a total sample of 19. R27 receives renal dialysis three days per week. R27's care plan did not reflect the necessary care and treatment approaches for a resident receiving dialysis, including approaches for emergency situations related to hemodialysis access site. This is evidenced by: The facility policy and procedure entitled "End-Stage Renal Disease, Care of a Resident with {sic} undated, includes, in part: Residents with End-Stage Renal Disease (ESRD) will be cared for according to currently recognized standards of care. 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the	F 698		

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facility, shall be trained in the care and special needs of these residents.
2. Education and training of staff includes, specifically:
a. The nature and clinical management of ESRD.
b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis.
c. Signs and symptoms of worsening condition and/or complications of ESRD.
d. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections.
g. The care of grafts and fistulas.
4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, included:
b. How information will be exchanged between the facilities.
5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

R27's care plan problem, date initiated 5/11/18, related to hemodialysis r/t (related to) ESRD: "The resident needs hemodialysis r/t ESRD: Goal: The resident will have no s/sx (signs/symptoms) of complications from dialysis through the review date." Interventions, undated, included: "Attends dialysis on M-W-F (Monday-Wednesday-Friday) p/u (pick up) time 11:30. ...Check and change dressing daily at access site. Document. Do not draw blood or take B/P (blood pressure) in left arm."

R27's most recent Physician's Orders, signed 8/6/18, include, in part, the following:

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F 698	Continued From page 38 Dialysis site in right upper chest three times a day for dialysis site. R27's Dialysis Care Plan did not identify how R27's dialysis access site should be assessed/cared for on a daily or per shift basis as according to their policy. R27's medical record has no documentation of the checking and changing of the dressing at the access site on a daily basis, there is no documentation of information exchanged between the facilities, and there is information or what staff should do if bleeding occurs from R27's dialysis site. On 8/15/18 at 10:19 AM, Surveyor interviewed LPN T (Licensed Practical Nurse). Surveyor asked LPN T if he monitors and documents the monitoring of R27's access site. LPN T stated he would look at the access site when he works with R27. LPN T reviewed R27's medical record stating he could not find any documentation related to monitoring of R27's access site. On 8/16/18 at 10:13 AM, Surveyor interviewed DON B (Director of Nursing). DON B stated she could not show the facility staff monitored R27's access site. DON B stated the access site should be monitored and documented. DON B stated she was not sure if the access site dressing was checked and changed on a daily basis, however, this should be on the TAR (Treatment Administration Record) to show that it is done as care planned. DON B stated she was unsure if there is any documented communication between the facility and the dialysis center, however, DON B stated the dialysis center can be reached via telephone.	F 698		
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		

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F 758 SS=D	Continued From page 39 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not ensure resident's drug regimens are free from unnecessary psychotropic drugs for 1 out of 2 residents (R25) reviewed for unnecessary medications out of a total of residents 19 sampled.

R25's Physician Orders for Haldol and Lorazepam prn (as needed) was written 7/2/18. The facility continued to administer the prn Haldol and Lorazepam past 14 days without physician's continuation order.

Evidenced by:

The facility's policy entitled "Antipsychotic Medication Use," dated 3/2017, includes, in part, the following:
5. Residents who are admitted from the community or transferred from a hospital that are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team (IDT) will: b. Re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks to consider whether or not the medication can be reduced, tapered, or

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discontinued.
14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order.
15. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication.

R25's diagnoses include dementia, depression and anxiety. R25's Healthcare Power of Attorney is activated and R25 is not his own decision maker.

R25's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/9/18 indicates R25.

R25 has severe cognitive impairment, has no behaviors and transfers with extensive assistance of 2 persons.

R25's Admission Orders, signed 6/14/18, include, in part, the following:
Haloperidol (Haldol) (an anti-psychotropic) 0.5 mg (milligram) to 1 mg every 4 hours PRN, restlessness, agitation, nausea or hiccups. Give 0.5 mg for mild to mod (moderate) symptoms and 1 mg for severe symptoms.
Lorazepam (an antianxiety) 0.5 mg every 4 hours PRN anxiety, or restlessness.

(It is important to know that R25 was admitted to the facility on 7/2/18 and these PRN orders would need to be renewed on or before 7/16/18 to remain in effect. The medications were not renewed until 8/6/18.)

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F 758	Continued From page 42 R25's 7/2018 and 8/2018 MAR (Medication Administration Record) includes, in part, the following dates the Haldol and Lorazepam PRN medications were administered: Haloperidol give 0.5 mg by mouth every 4 hours as needed ... This medication was administered the following date: 7/23/18. Haloperidol give 1 mg by mouth every 4 hours as needed ... This medication was administered the following dates: 7/19/18, 7/21/18, 7/24/18, 7/27/29, 7/29/18, and 8/1/18. Lorazepam give 0.5 mg by mouth every 4 hours as needed ... This medication was administered the following dates: 7/19/18, 7/23/18 and 8/5/18. On 8/16/18 at 1:00 PM, Surveyor interviewed RPh U (Registered Pharmacist). RPh U stated she did review R25's medications on 7/25/18. RPh U stated she looked at R25's Lorazepam and Morphine and was concerned about the interactions between these medications. RPh U stated she did not address the Haldol, even though she did know that it should have been addressed. RPh U stated the Haldol and Lorazepam PRN orders should have been addressed by R25's provider within 14 days of his admission in order for them to continue.	F 758		
F 812 SS=K	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		

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from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety for 6 of 40 residents as the facility served unpasteurized, fried eggs that were not thoroughly cooked to 6 of 40 residents for breakfast on 8/14/18 (R18, R3, R39, R190, R26, and R5).

Failure to ensure that eggs served were pasteurized or fully cooked placed these residents at risk for becoming infected by Salmonella and created a finding of Immediate Jeopardy (IJ). The facility administrator was made aware of the findings of IJ on 8/14/18 at 8:30 AM, which was removed on 8/14/18. The deficiency continues at a scope/severity of E (potential for harm that is not IJ/pattern) as the facility continues to implement its removal plan.

Findings include

The 2013 Food Code states, "People can become infected by Salmonella by eating foods contaminated by the bacteria. Contaminated

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items are often of animal origin, such as beef, poultry, unpasteurized milk or eggs."

The 2017 Food Code states, "3-801.11 Pasteurized Foods, Prohibited Re-Service, and Prohibited Food.

In a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION:

(B) Pasteurized EGGS or EGG PRODUCTS shall be substituted for raw EGGS in the preparation of...
(2) A partially cooked animal FOOD such as lightly cooked FISH, rare MEAT, soft-cooked EGGS that are made from EGGS, and meringue;"

The facility does not have a policy regarding the use of unpasteurized eggs or the safe handling and/or cooking of shell eggs.

On 8/14/18 at 7:30 AM, while walking through the dining room on the way to the facility's main kitchen, Surveyor observed R18 and R3 eating fried eggs with visible runny yokes. Both residents' eggs had only been half eaten. Surveyor approached R18 and R3 and asked how often they order fried eggs, to which both replied "all the time." Surveyor proceeded to the kitchen.

At 7:35 AM, Surveyor asked DA C (Dietary Aide) if she had used shelled eggs to make fried or over-easy eggs this morning and, if so, where those eggs were located. DA C stated yes and proceeded to the refrigerator where she pointed at a half-empty case of eggs. The eggs, nor the box they were in, had any visible markings that

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the eggs were pasteurized.

On 8/14/18 at 7:41 AM, Surveyor interviewed DM D (Dietary Manager). DM D stated the eggs were pasteurized and did not know why the eggs, nor the box, had any markings indicating that the eggs were pasteurized. DM D stated she had recently gotten the eggs from her dairy supplier, not her usual egg distributor. DM D then provided Surveyor with a purchase order, dated 7/26/18, which indicated eggs were ordered. The purchase order did not state whether the eggs were pasteurized or not. Additionally, DM D provided the contact of the distributor that provided her dairy supplier with the eggs. DM D also provided a list of all residents that ordered from their "always available" menu, which includes fried eggs for breakfast. The list included R18, R3, R39, and R26, all of which have BIMS (Brief Interview for Mental Status) scores of 15, indicating they are cognitively aware. The list also included R190, who did not yet have a BIMS score, but was also cognitively alert and aware.

On 8/14/18 at 8:51 AM, DM D, after contacting her supplier, confirmed that the eggs were not pasteurized. DM D stated they were running out of eggs and did not believe, at the time, that the facility egg supply would last until the next delivery by their usual food supplier. Instead, DM D had her milk supplier bring in some eggs to create enough supply to last until the usual food supplier made the regularly scheduled delivery. DM D stated she has never seen pasteurized eggs without the "P" designation on them. DM D also stated that she should have inspected and noticed the eggs were not pasteurized and made dietary plans accordingly. Additionally, DM D stated she would expect her staff to be aware of

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what constitutes a pasteurized egg and what does not ("P" stamp) and notify her or the administrator with any concerns.

On 8/14/18 at 9:06 AM, Surveyor spoke with PM E (Plant Manager). PM E, who runs the plant that distributed the eggs to DM D's dairy supplier, confirmed the eggs were not pasteurized.

Surveyor interviewed R39, R190, R26, and R5, who were all provided by DM D on the list of residents that ordered fried eggs on the morning of 8/14/18. All confirmed they received fried eggs with runny yokes on the morning of 8/14/18. Additionally, all indicated that their eggs were a bit runnier than they'd normally prefer.

Serving unpasteurized eggs that were not fully cooked created the potential that residents could contact Salmonella. This created a finding of IJ. The IJ was removed on 8/14/18 when the facility began implementing the following:

*All unpasteurized eggs were removed from the facility and discarded, by the Dietary Manager, on 8/14/18 at 10 AM.

*Residents who received eggs that were soft or cooked to order will be monitored for signs of food borne illness, including fever, abdominal pain, nausea, vomiting, diarrhea every shift for 72 hours then daily for an additional 48 hours. The monitoring of these conditions was set up in the eMar (electronic) system on 8/14/18 at 2:30 PM. Any identified signs will immediately be reported to the attending physician or nurse practitioner. The Medical Director and attending physician/nurse practitioner for the residents involved were notified of the potential hazard

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F 812	Continued From page 47 related to egg consumption. *Education regarding use of only pasteurized eggs was provided to the Dietary Manager and the cooks on duty on 8/14/18, and will be conducted with all oncoming cooks prior to beginning next shift. *The Dietary Manager was educated on 8/14/18 by the registered dietician to review the menus for the period to be covered by the food order, to estimate the quantity of eggs needed and avoid the need to make emergency purchases from other vendors. *The administrator will monitor order sheets and purchase orders to assure that only approved vendors are utilized and will verify that no unpasteurized eggs are on the invoices. She, or in her absence, an educated designee, such as the Dietician or Director of Nursing will make rounds in the dietary department weekly on Mondays and Thursdays for 4 weeks on the day the food delivery occurs to verify that only pasteurized eggs are present. After that time, eggs will be checked weekly for 3 months to verify that they are pasteurized. If no further issues identified, monitoring will be completed with scheduled dietary sanitation audits as part of the Quality Improvement Program.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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F 880	Continued From page 48 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility did not maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. This had the potential to affect all 40 residents in the facility.

The facility's Infection Control Program did not consistently calculate overall and /or site specific incident rate of infections for monitoring and analysis.

The facility does not maintain a surveillance log of residents whose symptomatology may be indicative of an infection, but are not on antibiotic therapy, for monitoring and analysis.

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F 880	Continued From page 50 The facility does not update their Surveillance Logs on a daily basis to maintain current, up-to-date infections within the facility for daily monitoring and analysis. The facility had no evidence of when transmission based precautions were discontinued. This is evidenced by the following: Example 1 On 8/14/18 at 9:00 AM, Surveyor reviewed the facility's Infection Control Surveillance documentation as part of the facility's Infection Control Program review. Surveyor noted the following during this review: March 2018 *There is no evidence that site - specific incident rate of infections were calculated for review and analysis. *There is no evidence of a Surveillance Log of residents whose symptomatology may have been indicative of an infection (fever, cough, diarrhea, vomiting, malaise, etc...), but were not on antibiotic therapy, for monitoring and analysis. *There is no evidence an overall incident rate of infection was calculated for review and analysis. *The facility does not update their Surveillance Logs on a daily basis to maintain current, up-to-date infections within the facility for daily monitoring and analysis. April 2018	F 880		

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F 880	Continued From page 51 *There is no evidence that site - specific incident rate of infections were calculated for review and analysis. *There is no evidence of a Surveillance Log of residents whose symptomatology may be have been indicative of an infection (fever, cough, diarrhea, vomiting, malaise, etc...) but were not on antibiotic therapy, for monitoring and analysis. *There is no evidence an overall incident rate of infection was calculated for review and analysis. *The facility does not update their Surveillance Logs on a daily basis to maintain current, up to date infections within the facility for daily monitoring and analysis. May 2018 *There is no evidence that site - specific incident rate of infections were calculated for review and analysis. *There is no evidence of a Surveillance Log of residents whose symptomatology may have been indicative of an infection (fever, cough, diarrhea, vomiting, malaise, etc...), but were not on antibiotic therapy, for monitoring and analysis. *There is no evidence an overall incident rate of infection was calculated for review and analysis. June 2018 *There is no evidence that site - specific incident rate of infections were calculated for review and analysis. *There is no evidence of a Surveillance Log of residents whose symptomatology may have been indicative of an infection (fever, cough, diarrhea, vomiting, malaise, etc...), but were not on antibiotic therapy, for monitoring and analysis. *There is no evidence an overall incident rate of	F 880		

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infection was calculated for review and analysis.
*The facility does not update their Surveillance Logs on a daily basis to maintain current, up to date infections within the facility for daily monitoring and analysis.

July 2018

*There is no evidence that site - specific incident rate of infections were calculated for review and analysis.
*There is no evidence of a Surveillance Log of residents whose symptomatology may have been indicative of an infection (fever, cough, diarrhea, vomiting, malaise, etc...), but were not on antibiotic therapy, for monitoring and analysis.
*There is no evidence an overall incident rate of infection was calculated for review and analysis.
*The facility does not update their Surveillance Logs on a daily basis to maintain current, up-to-date infections within the facility for daily monitoring and analysis.

August 2018

*There is no evidence that site - specific incident rate of infections were calculated for review and analysis.
*There is no evidence of a Surveillance Log of residents whose symptomatology may have been indicative of an infection (fever, cough, diarrhea, vomiting, malaise, etc...), but were not on antibiotic therapy, for monitoring and analysis.
*There is no evidence an overall incident rate of infection was calculated for review and analysis.
*The facility does not update their Surveillance Logs on a daily basis to maintain current, up to date infections within the facility for daily monitoring and analysis.

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F 880	Continued From page 53 Example 2 R14 complained of respiratory symptoms on 1/17/18. She was positive for Influenza-A on 1/18/18 and never added to Resident Monthly Line List for current or potential infections. R14 was placed on Tamiflu on 1/18/18. Example 3 R26 began having respiratory symptoms on 2/19/18 and was never added to the Monthly Line List. R26 had an influenza swab on 2/19/18 that was negative. R26 was placed on droplet precautions though record review does not indicate when precautions were discontinued. On 8/15/18 at 9:00 AM, Surveyor interviewed DON B (Director of Nursing) and NC Q (Nurse Consultant) about the facility's Infection Control Program. DON B stated that the facility does look at resident symptoms daily, but does not have a current method to track or tend symptoms, but should have and they will be working on this. Surveyor asked if they calculate the incident rate of infections both overall and site specific. DON B states she does not calculate the incident rate of infections.	F 880		