DEPARTMENT OF HEALTH AND HUM[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER FAIR OAKS	11300 FAIR OAKS BLVD. FAIR OAKS, CA 95628

acceptable POC 109 HFEN 4/30/19

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. Representing the Department of Public Health: HFEN, 36524 HFEN, 36586 HFEN, 39797 HFEN, 40186 HFEN, 40841 HFEN, 40154 HFEN, 41197 HFEN, 40214 The sample size was 32 based on a census of 144.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		

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

[signature] Administrator 4/23/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F550

A. Each infraction cited occurred while staff were communicating directly and/or responding to the surveyor. Their comments were not directed towards or in the immediate presence of resident 99, 126, 58, or 332.
B. Historically, in a professional context, terms such as "feeder" or wanderer" were acceptable to describe those who required assistance with feeding or those that ambulate without specific intended destinations, respectively. No residents were affected by this practice.
C. All staff will be inserviced to avoid the use of such terms as "feeder" or "wanderer", even in a professional context with one another and commit to "person-centered" language. The use of such institutional/clinical language may be unintentionally demeaning to others.
D. A Pre/Post-test has been devised with structured questions to retrain employees to use "person-centered" language. The Quality Assurance Nurse and Director of Staff Development will facilitate the implementation of the Pre-/Post-test. To ensure sustained corrective action and evaluate for effectiveness the QA nurse will randomly ask five (5) employees, five (5) questions monthly x 3 months. Results will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee.
E. The facility will ensure substantial compliance by Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F552

A. A collaborative effort was ongoing at the time of the inadvertent administration of the medication for resident 483. Immediate corrective action occurred upon the realization that an error occurred with physician and resident/responsible party notification.
B. All residents prescribed an antipsychotic have been reviewed. No other residents have been found to be affected.
C. Root cause analysis revealed the availability of the drug in the medication cart prior to completion of the process of obtaining informed consent a contributory factor. Therefore, antipsychotic medications will not be placed in the medication cart for administration until after the verification of informed consent process has been completed. Additional directives will be included within the body of the order to indicate to **"HOLD – INFORMED CONSENT PENDING"** to alert the licensed/professional nurse of the pending status. A holding bin has been placed in each medication room. As medications arrive from the pharmacy, psychotherapeutic medications will be placed in the bin and not in the medication cart until verification of the informed consent has been completed.
To facilitate monitoring the charge nurse/supervisor will include in their daily reporting the total number of residents with pending verification of informed consent for psychotherapeutic medications. The charge nurse/supervisor will also monitor the process. Upon completion of the verification process, the medication will be retrieved from the storage bin in the medication room and be made available on the medication cart. Report worksheets and DON Morning Meeting Notes worksheets updated on 3/20/2019
D. A QAPI audit tool has been developed to both audit and monitor and evaluate the effectiveness of the actions taken. The audit will be completed by the Health Information Manager or designee each business day. The reports will then be forwarded to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) for review. A compliance score will be calculated weekly and findings reported to the QAPI committee monthly for 3 months.
E. The facility will ensure substantial compliance by Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F684

A. Although the functional status of Resident 100 may vary slightly over the course of the day, she is usually independent with bed mobility in turning left and right. She requires extensive assistance to reposition "up" in the bed. Resident frequently declines to adhere to a scheduled timed interval repositioning schedule as noted on 12/18/2018. Order to turn every two hours has been discontinued.
B. All residents at risk for skin breakdown/failure have been reviewed. No other residents have been affected by this practice.
C. Each individual resident will be evaluated using the Braden Risk Assessment according to organizational policy. An individualized person-centered comprehensive care plan will be developed based on the resident assessment, risk factors, functional status and resident preference and/or choices in accordance with current standards of practice. IDT will review the care plan quarterly and as needed to address appropriateness of interventions and resident preferences. Charge nurses/ unit managers, as well as other interdisciplinary team members, will provide ongoing review and revision of the care plan and interventions as necessary.
D. A section has been added/designated on the LTC Clinical Stand Up worksheets to report and address declination of services and/or prescribed treatments to the interdisciplinary team. Based on the information provided, the IDT will discuss, review and edit the plan of care. Using the daily clinical report forms, the DON/ADON will audit the occurrences of refusals/declination of prescribed treatments, IDT review, and management of care plan. All findings including trends and patterns identified will be reported to the QAPI committee monthly for three (3) months to ensure that sustained correction has occurred.
E. The facility will ensure substantial compliance by Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F689

A. The facility has ensured that there is a smoking apron available in all designated smoking areas. Resident 101 is assisted with the application of the smoking apron when provided with smoking materials.
B. All residents who smoke may be at risk for injuries related to smoking activities. No other residents have been noted to be affected by this practice.
C. A smoking assessment will be completed for all residents who smoke on 3/20/2019 to assist the interdisciplinary team (IDT) to evaluate and analyze the hazards and risk to the residents. Based on the assessment tool, the IDT will review and/or revise interventions to reduce hazard and risks and eliminate them where possible. An individualized person-centered care plan consistent with the residents' needs and goals will be developed. A communication tool will be developed and posted on the CNA communication board to facilitate the understanding and awareness of the patients specific needs.
D. An audit tool has been created to randomly observe all residents who smoke at least once per month. Observed practices to be validated against the evaluation of current patient plan of care specific interventions. A compliance score will be calculated by the DON/ADON and reported to the QAPI committee monthly for 3 months.
E. The facility will be in substantial compliance and staff will be inserviced no later than Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F700

A. Side rails have been used as an enabler for a significant number of our residents. No residents have been negatively impacted by this practice.
B. All residents in-house on 2/22/2019 were evaluated while in bed for the risk of entrapment from bed rails. To ensure that there was no risk for entrapment from bed rails. No residents were affected by this practice.
C. An audit has been conducted of all patients in the facility to identify patients/residents
   a. That would prefer to keep their side rails for psychosocial well-being such as feelings of "safety" when upper rails are elevated.
   b. Require the assistance of the side rails as an enable to enhance their ability to assist and/or actively participate with functional ADL care and services
   c. Those who do not require the use of the upper rails as an enabler.

   An observation/assessment will be completed on those patients and residents who are in categories (a) and (b). Those who do not require side rails (category c) will have the side rails removed. The facility will continue to assess each patient/resident for entrapment and the need for the upper rails to assist with functional ADL tasks. Side rails will be installed only on patients who have been assessed to require side rails for mobility/request side rails after an explanation of risk vs benefit and consent has been obtained. Each resident will then also be assessed for risk for entrapment while in bed and the intervention will be care planned accordingly.
D. The unit manager will bring all bed rail assessments for new admissions to the morning stand up meeting to ensure completion and accuracy for comparison with all new admissions and discharges.
E. The facility will ensure substantial compliance by Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F758

A. Resident 438 inadvertently received the antipsychotic prior to completion of the process of verification of informed consent on 2/19/2019. The attending physician obtained informed consent for continuation of the prescribed medication on 2/20/2019. Monitors for behavioral manifestations, adverse side effects were added on 2/20/2019.
B. All residents receiving antipsychotic medications were reviewed. No other residents were noted to be affected by this practice.
C. When an order is received for a psychotherapeutic medication, understanding that all data points related to the specific behavioral manifestations may not be available, a reasonable attempt will be made to determine the specific behavior that medication is intended to address. A monitor will be created and entered into the Electronic Health Record (EHR). When medication is administered a monitor will be added for the observation of adverse side effects.
D. Medical Records will audit all new admissions for compliance with a separate specific care plan for psychotherapeutic drug use, verification of informed consent, corresponding specific behavioral manifestations, non-drug interventions and methods for evaluation of effectiveness. The reports will be forwarded to the DON/ADON. Trends and/or patterns identified will be reported to the QAPI committee monthly for three (3) months.
E. Licensed staff will be inserviced to this procedural change in process no later than Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F812

A. No residents were affected in the examples noted
B. The CNA that used her bare hands, was in-serviced immediately on the proper infection control techniques when assisting a resident with meals. The thickener was labeled immediately, and the 6 expired spice containers were discarded.
C. The Infection Preventionist in serviced all CNAs between February 19th and February 22nd on the proper infection control techniques that need to be used when assisting a resident with meals. A glove dispenser was placed on the wall in the dining room for CNA use. The Food Nutrition director or designee will inspect the spice expiration dates monthly and be recorded on the "Rounds Checklist". Any spices that are expected to expire prior to the next inspection will be discarded. The label on the storage bin containing the thickener is a permanent fix and requires no regular inspection.
D. The dietary consultant will specifically inspect for proper labelling, and expiration dates on her monthly visits for three months. The Infection preventionist will monitor the CNAs in the dining room for proper infection control technique when CNAs assist residents with their meals 3 times per week for one month and then one time per week for two months. A dining room observation form will be used to document the observations. Results of their audits will be produced for the QA team to ensure the results are acceptable, and sustained.
E. All training and corrections will be achieved by the 22nd of March.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F842

A. A baseline care plan for this patient was completed within 48 hours of admission on February 9, 2019. The comprehensive minimum data set was completed on February 22, 2019. All necessary comprehensive care plans had been developed reflective of the patient's stated goals and objectives, prior to receipt of this 2567. The patient has discharged home.
B. All residents admitted to the facility are reviewed and audited for compliance for the development of a Baseline care plan within 48 hours. No residents are out of compliance.
C. The baseline care plan is developed within 48 hours of admission and will now include a separate care plan for psychotherapeutic medication use. Understanding that all data points related to the specific behavioral manifestations may not be available, a reasonable attempt will be made to determine the specific behavior intended to address, side effects, non-drug interventions and a method of evaluating effectiveness of the medication.
D. Medical Records will continue to audit all new admissions for compliance with a separate specific care plan for psychotherapeutic drug use, verification of informed consent, corresponding specific behavioral manifestations, non-drug interventions and methods for evaluation of effectiveness. The reports have been forwarded to the DON/ADON. Reports are reviewed for trends and/or patterns. Any identified will be reported to the QAPI committee monthly for three months.
E. The facility ensured substantial compliance prior to Friday, March 22, 2019.

Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulations (CFR):

F880

A. Resident 111 has been discharged from the facility.
B. Although all residents receiving intravenous therapy could have been potentially affected by this practice, no residents were noted to be affected by this practice.
C. Each professional nurse that performs infusion therapy will be provided the policy for "Flushing a Vascular Access Device." Each nurse will then demonstrate competency using the IV skills validation competency checklist for "Flushing a Vascular Access Device" using the Chester Chest anatomical model no later than Friday, March 22, 2019.
D. The competency validation checklist will be repeated monthly with at least 2 professional nurses x 3 months to ensure sustained corrective action.
E. All professional nurses will be in substantial compliance no later than Friday, March 22, 2019.

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dignity and respect were maintained when staff referred to the residents as "feeders" for 5 residents (Resident 99, Resident 120, Resident 27, Resident 58, and Resident 332) for a census of 144. These failures increased the potential to diminish residents' self-esteem and self-worth. Findings: Review of the Admission Records indicated the following:	F 550		

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F 550	Continued From page 2 Resident 99 was admitted to the facility in mid-2018 with diagnoses which included difficulty swallowing and slurred speech. Resident 120 was admitted to the facility in mid-2017 with diagnoses which included difficulty swallowing. Resident 27 was admitted to the facility in mid-2015 with diagnoses which included memory loss, tremors and muscle rigidity. Resident 58 was admitted to the facility in mid to late 2015 with diagnoses which included memory loss, dehydration, and difficulty breathing. Resident 332 was admitted to the facility in early 2019 with diagnoses which included memory loss. During an observation and concurrent interview on 2/21/19 at 12:35 p.m., Resident 99, Resident 120 and Resident 332 were in the Barrington hall mini-dining room. Licensed Nurse 5 (LN 5) referred to the residents as "feeders" while talking to this surveyor as she stood in the hallway 2 feet from the dining room. During an observation and concurrent interview on 2/21/19 at 12:55 p.m., Certified Nurse Assistant 5 (CNA 5) referred to Resident 58 and Resident 27 as "feeders" while talking to this surveyor as she stood by the entrance betweeen Resident 58 and Resident 27 rooms. A review of the facility's in-service provided document titled Class Handout: Dignity and Reasonable Accommodation of Needs indicated, "Residents have the right to be treated with	F 550		

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F 550	Continued From page 3 respect. Calling the resident by their last name ...unless they tell you they prefer another name. All residents will be treated in a manner which maintains and enhances their dignity." Review of the facility's record titled "Your Resident's Rights", indicated that residents are "To be treated with ... respect, and full recognition of dignity, individuality, including... treatment and care of personal needs." In an interview on 2/22/19 at 10:50 a.m., the Director of Nursing (DON) stated that staff were expected to address the residents with their preferred names. The DON further stated that staff were expected to not address the residents who require feeding assistance "feeders." The DON acknowledged that it was considered a dignity issue.	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed	F 552		

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F 552	Continued From page 4 care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to directly involve a resident and resident's representative in their own treatment decisions for one of 32 sampled residents (Resident 483) when consent for a psychotropic medication was not obtained prior to administration. This failure resulted in the resident receiving treatment that they did not approve nor was adequately explained to them. Findings: Resident 483 was admitted to the facility in 2019 with diagnoses which included stroke, episodes of fainting, low blood pressure, and a generalized anxiety disorder. Review of Resident 483's clinical record included: A physician order, dated 2/9/19, directed, "Resident does not have the capacity to understand choices and make healthcare decisions." A physician order dated 2/15/19 for [olanzapine] (a medication that affects brain activities associated with mental processes and behavior) 2.5 mg (milligrams, a medication dose measurement) orally to be given at bedtime. No diagnosis or specific behavior manifestation to be treated was present in the order. No behavioral or side effect monitoring was ordered. A physician notification form, dated 2/15/19,	F 552		

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F 552	Continued From page 5 indicated the resident had an order for [olanzapine], and there was no informed consent for the medication from Resident 483's son. A physician's written response on the physician notification form, dated 2/16/19, to hold the [olanzapine]. A medication administration record, dated 2/19/19, indicated Licensed Nurse (LN) 6 administered [olanzapine] 2.5mg at 9:24 p.m. A "Verification of Informed Consent" form signed by the resident's physician for medication [olanzapine], dated 2/20/19, one day after the medication was administered. A progress note, dated 2/21/19, from LN 6 who administered the [olanzapine] on 2/19/19, indicated the doctor and the resident's son were notified the medication was given. In an interview on 2/21/19 at 10:47 a.m. with LN 1, she stated medications like [olanzapine] cannot be given without informed consent. In an interview and subsequent record review of Resident 483's medication administration record conducted on 2/22/19 at 8:05 a.m. with LN 2, LN 2 confirmed the medication was given on 2/19/19 and she did not know why the medication was given without informed consent. A facility policy titled Psychotropic Medication Use, dated 8/25/17, stipulated "Prior to the administration of psychotropic medications, the nurse shall verify that the resident's health record contains documentation that resident/representative has given informed	F 552		

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F 552	Continued From page 6 consent to the physician, including those residents admitted with pre-existing orders for psychotropic medications." In an interview with the Director of Nursing on 2/22/19 at 10:25 a.m., she stated the nurse needed to verify consent was obtained prior to administering medications such as [olanzapine].	F 552		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were turned every two hours as ordered by the physician for 1 of 32 sampled residents (Resident 100). This failure resulted in Resident 100 not receiving the needed treatment and care to prevent worsening of pressure ulcer (localized damage to the skin and/or underlying tissue). Findings: Review of the clinical record for Resident 100 included:	F 684		

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F 684	Continued From page 7 An Admission Record indicated Resident 100 was admitted to the facility mid to late 2016 with diagnoses which included stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone) pressure ulcer of sacral (buttocks) region. A Minimum Data Set (MDS, an assessment tool) on admission, indicated the resident scored 15 out of 15 possible points on the Brief Interview for Mental Status (BIMS), which indicated no memory deficit. The MDS, indicated the resident had an unhealed stage IV pressure ulcer and "at risk of developing pressure ulcers." The MDS, indicated the resident needed extensive assistance with Assistance of Daily Living (ADLs) -bed mobility and transfer. A physician's order, dated 10/23/18, indicated that the resident was to be on "Turning protocol every 2 hours to sides." A Care Plan initiated on 8/26/16, indicated "Assist /encourage resident to turn and reposition frequently." An observation on 2/19/19 of Resident 100 included: 8:40 a.m. - resident was observed in bed on her back. 10:30 a.m. - resident was in bed on her back, watching television. 12:30 p.m. - resident was in bed eating lunch. 2:30 p.m. - resident on her right side, propped with pillows.	F 684		

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F 684	Continued From page 8 3:50 p.m. - Licensed Nurse (LN) 3 turned resident to right side and provided wound care. The wound had full-thickness tissue loss with no exposed bone, muscle or tendon. LN 3 changed the dressing and turned resident on her back. 4:30 p.m. - resident in bed on her back watching television. During an interview on 2/19/19 at 8:55 a.m., LN 3 stated that Resident 100 was only repositioned when needed. During an interview on 2/19/19 at 10:30 a.m., Resident 100 stated, "No one has repositioned me." An observation on 2/20/19 of Resident 100 included: 7:55 a.m. - resident was in bed eating breakfast. 9:50 a.m. - resident was in bed on her back. 11 a.m. - resident was out of the room. 2:30 p.m. - resident was in bed on her back. 4:30 p.m. - resident was in bed on her back. During an interview on 2/20/19 at 7:55 a.m., Resident 100 stated, "Woke up 5 a.m., took my medications, laying in bed on my back. Went back to sleep and woke up 7:20 a.m. in the same position. No one has turned me." During an interview on 2/20/19 at 9:50 a.m., Resident 100 stated, "Nobody has been turning	F 684		

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F 684	Continued From page 9 me or told me to turn." During an interview on 2/20/19 at 4:30 p.m., LN 3 stated that the resident was repositioned but not every two hours. Review of Activities for Daily Living (ADLs) for Resident 100 dated 2/9/19 and 2/19/19, indicated there was no documented evidence that Resident 100 was on a turning schedule every two hours. Review of facility document titled, "Skin Integrity Protocol" revised 3/3/11, indicated, " Treatment orders must be continued until a discontinue order is received ...A care plan will be implemented for each site ...Preventive measures ...include ...repositioning." During an interview on 2/22/19 at 10:50 a.m., the Director of Nursing (DON) stated that there was no policy for repositioning. DON further stated that if resident was identified in the MDS for at risk of pressure ulcers, it should be care planned. DON acknowledged that care plan and order should have been followed.	F 684		
F 689 SS=D	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:	F 689		

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F 689	Continued From page 10 Based on observation, interview, and record review, the facility failed to ensure the use of a smoking apron during smoking breaks for 1 resident (Resident 101), for a sample size of 32. This failure increased the risk for Resident 101 to sustain burn injuries. Findings: Resident 101 was admitted to the facility in late 2013 with diagnoses including stroke. Resident 101's Minimum Data Set (MDS, an assessment tool), dated 1/16/19, indicated a Brief Interview of Mental Status (BIMS, a cognitive assessment tool) of 15/15, indicating Resident 101 was cognitively intact. The MDS indicated Resident 101 required 1-person assistance to perform personal hygiene functions. Review of Resident 101's clinical record indicated a Physician's Order with a start date of 1/30/19 for "divalproex [a medication] ...FOR TREMORS." During two separate observations on 2/19/19 at 12:01 p.m., and 2/20/19 at 7:27 a.m., Resident 101 was observed smoking on the Douglas patio without a smoking apron and without staff supervision. Resident 101 was observed with bilateral hand tremors. During an interview with Resident 101 on 2/20/19 at 7:35 a.m., Resident 101 stated she lights her own cigarettes. She stated she smokes 1-2 cigarettes before and after breakfast, lunch, and dinner. Resident 101 denied she was supervised by staff while she smoked. Resident 101 stated, "The nurse makes me a cup of coffee before I go out [for a smoke]. I have tremors and it's gotten	F 689		

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F 689	Continued From page 11 bad. I can't do it [make a cup of coffee] myself anymore." During an interview with Licensed Nurse (LN) 9 on 2/20/19 at 10:15 a.m., LN 9 stated Resident 101 wore her smoking apron 60% of the time while she smoked. LN 9 stated Resident 101 required a smoking apron because of her tremors. Review of Resident 101's Care Plan titled, "RESIDENT IS AN ACTIVE SMOKER," dated 1/15/15, indicated, "SMOKING APRON ON WHENEVER SHE IS GOING OUT TO SMOKE AS SHE HAS BILATERAL HAND TREMORS." Review of Resident 101's Smoking Risk Assessment dated 1/22/19, indicated Resident 101 "Requires Smoking Apron." A review of the facility policy titled, "SMOKING," revised 12/23/14, indicated, "All residents who smoke will be required to participate in a Resident Smoking Assessment conducted by a member of the interdisciplinary team to determine whether they exhibit the ability to smoke safely. As a result of the assessment, resident may require supervision and/or a smoking apron while smoking for safety." During an interview with the Director of Nursing (DON) on 2/22/19 at 10:37 a.m., the DON confirmed Resident 101 did not wear an apron every time she smoked. During an interview with LN 9 on 2/22/19 at 11:30 a.m., LN 9 stated Resident 101 sometimes forgets to wear her smoking apron, but she is compliant with wearing the apron when asked to.	F 689		

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F 689	Continued From page 12 LN 9 stated, "She never refuses." LN 9 stated Resident 101 has tremors and needs the apron. LN 9 stated both the nurses and Certified Nursing Assistants were aware of what was on a residents' care plans. She stated she expected the care plans to be implemented and carried out.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure side rail (SR) assessments for entrapment (a position or situation from which it is difficult or impossible to escape) risk were completed prior to resident	F 700		

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F 700	Continued From page 13 use for a census of 139 of 144 Residents. This failure had the potential to cause restricted exit from bed, increased risk of injury, and lead to a decline in functional status (an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being). Findings: During observations conducted on 2/19/19 to 2/22/19, the bilateral (on each side of the bed) upper side rails were observed in the upward position on 139 of 144 Resident's beds. During an interview on 2/22/19 at approximately 9:00 a.m., with the Licensed Nurse (LN) 7, when asked to provide information to validate the Residents' were assessed for entrapment risk due to side rail use. LN 7, expressed an entrapment assessment had not been completed because "... all of the mattresses are the same size. We do have new beds on [unit name] but they are not moved from unit to unit. All of the deminsions and size of the beds are the same..." During a concurrent interview on 2/22/19 at 9:30 a.m., with the Administrator and Director of Environmental Services (DES), the Administrator and DES confirmed the facility did not have a process in place to assess for entrapment risk. Per the DES, measurements were not taken for entrapment risk. The DES stated, "We only change the dimensions of the bed if the medical staff ask us to extend or widen the bed due to the Resident's size. We do no measure for entrapment risk." The Administrator agreed with the DES's statement.	F 700		

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F 700	Continued From page 14 During an interview on 2/22/19 at 11:08 a.m., the DON, confirmed the facility did not have a policy or process in place to assess for entrapment risk. The DON validated the use of upper side rails was the standard practice at the facility. Per the DON, "We use them (SR) as an enabler."	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use 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	F 758		

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F 758	Continued From page 15 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 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 observation, interview, and record review, the facility failed to identify and/or document a specific diagnosis or condition to necessitate the administration of a psychotropic medication for one of 32 sampled residents (Resident 483). This failure resulted in the resident receiving a medication without the proper monitoring or indication needed for appropriate use, effectiveness, and possible side effects, and therefore placed the resident at risk for harm. Findings: Resident 483 was admitted to the facility in 2019 with diagnoses which included stroke, episodes of losing consciousness, low blood pressure, and a generalized anxiety disorder. Review of Resident 483's clinical record included:	F 758		

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F 758	Continued From page 16 A physician order, dated 2/15/19, for [olanzapine] (a medication that affects brain activities associated with mental processes and behavior) 2.5 mg (milligrams, a medication dose measurement) orally to be given at bedtime. No diagnosis or specific behavior manifestation to be treated was present in the order. No behavioral or side effect monitoring was ordered. A medication administration history record, dated 2/1/19-2/22/19, indicated [olanzapine] 2.5mg was administered by a Licensed Nurse (LN) 6 on 2/19/19 at 9:24 p.m. In an observation on 2/19/19 at 8:15 a.m., Resident 483 was resting in bed and being informed by a staff member that breakfast would be coming soon. Resident was calm and agreeable with staff. Resident 483 did not appear agitated and spoke in a calm and quiet voice. The facility's policy titled Psychotropic Medication Use, dated 8/25/17, directed "Residents on psychotropic medications will be monitored for appropriate use, effectiveness, side effects, and possible dose reduction ...The physician order for psychotropic medications will include the name of the medication, dose, route, frequency, diagnosis, and the specific behavior manifestation to be treated." In an interview with Licensed Nurse (LN) 1 on 2/21/19 at 10:47 a.m., LN 1 reported the resident's behavior was monitored and charted every shift while on [olanzapine]. LN1 acknowledged the first charted behavior and side effect monitoring for [olanzapine] was on 2/20/19 for agitation on the evening shift.	F 758		

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F 758	Continued From page 17. An interview with LN 2 and concurrent record review was conducted on 2/22/19 at 8:05 a.m. LN 2 was unable to show behaviors and side effects for [olanzapine] were being monitored when the medication was administered on 2/19/19 at 9:24 p.m.	F 758		
F 812 SS=F	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 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 ensure residents were served food in accordance with professional standards for food service safety, for a census of 143, when: 1. A Certified Nursing Assistant (CNA) 4 was	F 812		

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F 812	Continued From page 18 observed picking up a dinner roll from residents' (Resident 72 and Resident 73) trays with her bare hands; 2. A storage bin contained an unidentified white powdery substance; and 3. 6 expired spice containers were available for use. These failures increased the potential for foodborne illness/allergies in a vulnerable population. Findings: 1. During a dining observation on 2/19/19 at 12:30 p.m., CNA 4 was observed delivering a meal tray to Resident 72. CNA 4 picked up the resident's dinner roll with her bare hands, cut and buttered it, and returned it to the resident's tray. CNA 4 then went back to the dining cart, removed another tray and delivered it to Resident 73. CNA 4 picked up the dinner roll with her bare hands, cut and buttered it, and returned it to the resident's tray. In an interview on 2/19/19 at 1:00 p.m., CNA 4 stated it was, "Probably not" facility policy to handle the residents' food with her bare hands. In an interview on 2/21/19 at 11:00 a.m., the Director of Staff Development (DSD) stated when plates are uncovered and staff are assisting residents with their meals, food cannot be touched with a bare hand. 2. During a kitchen tour on 2/19/19 beginning at 8:05 a.m., a storage bin containing a white	F 812		

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F 812	Continued From page 19 powdery substance was observed labelled with a best by date of 3/15/19, but did not identify what the item was. In an interview on 2/19/19 at 8:45 a.m., the Dietary Supervisor (DS) verified the white powdery substance in the bin was thickener, and it should have been labelled. According to the Federal Food Code 2017, Section 3-602.11 "Food Labels", it instructed, "Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement..." Section 3-302.12 "Food Storage Containers, Identified with Common Name of Food", also included, "Certain foods may be difficult to identify after they are removed from their original packaging. Consumers may be allergic to certain foods or ingredients. The mistaken use of an ingredient...may result in severe medical consequences." 3. 6 spice containers were observed to be labelled as follows: 1) Cayenne Pepper. Labelled with an open date of 10/2/17 and the manufacturer label indicated it expired on 9/22/16. 2) Oregano. No open date on container and the manufacturer label indicated it expired on 3/22/16. 3) Black Sesame Seeds. No open date on container and the manufacturer label indicated it expired on 12/19/16.	F 812		

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F 812	Continued From page 20 4) Baking Powder. No open date on container and the manufacturer label indicated it expired on 12/21/17. 5) Rubbed Sage. No open date on container and the manufacturer label indicated it expired on 8/17/17. 6) White Pepper. Labelled with an open date of 12/30/17 and the manufacturer label indicated it expired on 6/16/16. A review of the Food Storage facility policy, last revised on 10/29/18, stipulated, "Opened packages of dry food which are to be stored will be dated upon opening..." In an interview on 2/19/19 at 8:45 a.m., the DS confirmed it is the facility policy to label items with the open date. The DS confirmed several of the spice containers were expired or not labelled properly.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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F 842	Continued From page 21 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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	555153	A. BUILDING _____ B. WING _____	02/22/2019

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F 842	Continued From page 22 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document on the baseline care plan for one out of 32 sampled residents (Resident 483), information specific to the resident's immediate mental health and psychosocial monitoring and indication of treatment needs. This failure could result in patient care staff missing parts of Resident 483's individualized plan of care. Findings: Resident 483 was admitted to the facility in 2019 with diagnoses which included stroke, episodes of fainting, low blood pressure, and a generalized anxiety disorder. Review of Resident 483's clinical record included: A physician's order list containing the medications fluoxetine (a medication for depression) 10 mg (milligrams, a medication dose measurement) to be given daily starting 2/9/19, and trazadone (a medication for inability to sleep) 50mg to be given at bedtime as needed starting 2/12/19.	F 842		

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F 842	Continued From page 23 There was no documentation in the baseline care plan in Resident 483's record related to the indications of use and monitoring for side effects for the ordered medications fluoxetine and trazadone. A facility policy titled Psychotropic Medication Use, dated 8/25/17, directed "The care plan for each resident will specify the behavior and side effects to be monitored, non-drug interventions, and a method of evaluating the effectiveness of the medication." In an interview conducted on 2/22/19 at 10:25 a.m., the Director of Nursing stated the resident's care plans should reflect the specific mood and behaviors being monitored for residents receiving psychotherapeutic medications and the black box warning care plan does not take the place for those care plans.	F 842		
F 880 SS=D	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 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,	F 880		

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F 880	Continued From page 24 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. (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	F 880		

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F 880	Continued From page 25 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 failed to maintain aseptic techniques during medication administration for 1 resident (Resident 111), for a sample size of 6. This failure had the potential for Resident 111 to develop a blood infection. Findings: Resident 111 was admitted to the facility in early 2019 with diagnoses including osteomyelitis (a bone infection) of the lower leg. Review of Resident 111's clinical record indicated a physician's order with a start date of 1/16/19 for imipenem-cilastatin intravenous (an antibiotic medication administered directly into the veins) for osteomyelitis. During a concurrent interview and Medication Administration Observation by two surveyors from the Department on 2/20/19 at 8:07 a.m., Licensed Nurse (LN) 10 was observed touching the uncapped sterile tip of a flush (a syringe filled with fluid that is injected directly into a vein or artery) to her left gloved palm while she was cleaning the	F 880		

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F 880	Continued From page 26 port of the peripherally inserted central catheter (PICC, an intravenous catheter connected directly into a large blood vessel). When the Department interrupted LN 10 from connecting the flush to the PICC port and informed LN 10 of their observation, LN 10 stated she needed a new flush. During an interview with the Infection Preventionist (IP) on 2/21/19 at 10:58 a.m., the IP stated when accessing IV lines and PICCs, aseptic techniques should always be used. The IP stated the facility follows Association for Professionals in Infection Control and Epidemiology(APIC) and Centers for Disease Control and Prevention (CDC) guidelines for Infection Control and Prevention. During an interview with the Director of Nursing (DON) on 2/22/19 at 10:37 a.m., the DON concurred a contaminated flush should not be administered to a resident. A review of the facility policy titled, "Infection Control Program," revised 11/17/15 indicated, "The Governing Board, through the Quality Assessment and Assurance and the Infection Control Committee, has adopted infection control policies and procedures as those that best reflect the needs and operational requirements of this community in the prevention and transmission of infections and communicable diseases as set forth in current...CDC guidelines and recommendations." A review of the CDC guidelines titled, "Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011" (p. 28, 53) directed, "Maintain aseptic technique for the	F 880		

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F 880	Continued From page 27 ...care of intravascular catheters ...Minimize contamination risk by scrubbing the access port with an appropriate antiseptic ...and accessing the port only with sterile devices ..." Accessed on 2/28/19 at 3:04 p.m., URL: https://www.cdc.gov/infectioncontrol/guidelines/pdf/bsi/bsi-guidelines-H.pdf	F 880		