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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/8/18 through 10/12/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/12/18 and was removed on 10/12/18. An extended survey was conducted.	F 000		
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 record review, observations and interviews with residents and staff members, the facility failed to provide supervision to protect residents from physical and verbal aggression by one of six residents reviewed for prevention of accidents (Resident #78) resulting in physical assault on residents (#255 and #17) and threats of assault on other residents (#60 and #101). Immediate Jeopardy began on 08/12/18 when Resident #78 slapped Resident #255 in the face	F 689	F-689 Residents Affected: Resident #78 was moved to a private room on 9/13/18 to decrease agitation; and will remain in a private room. Resident placed on 1:1 supervision while awake. Resident□s 1:1 was started 10/11/18 at 4:00pm; and will continue until resident is evaluated by Psych. We will provide 1:1 for seven days and then	10/30/18

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

Electronically Signed | 10/31/2018

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F 689	Continued From page 1 and punched her in the chest, beginning a series of incidents in August and September 2018 in which Resident #78 physically assaulted two residents (#255 and #17) and threatened two other residents (#60 and #101) with assault. The Immediate Jeopardy was removed on 10/12/18 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and to ensure that monitoring systems put in place are effective to prevent resident-to-resident altercations. The findings included: 1. Resident #78 was admitted 09/13/17 with diagnoses that included unspecified dementia with behavioral disturbance, schizophrenia, major depressive disorder with psychotic features and anxiety disorder. Review of Resident #78's medical record revealed psychotropic medications were managed by an outside mental health consulting group. She attended appointments on 01/25/18 and 05/23/18. There were no medication adjustments on 05/23/18. There were no further appointments with the mental health group after 05/23/18. In an interview on 10/12/18 at 6:15 p.m., the Administrator explained that Resident #78 did not have regularly scheduled appointments with the mental health group. They were contacted on an as-needed basis for medication management.	F 689	re-evaluate resident□s status. The resident has been sent to Annie Penn hospital today, 10/12/18 for psych evaluation r/t continued agitation. Dr. Blass was contacted to address continued agitation and orders obtained to send resident to ER for continued agitation. The Medical Director, Dr. Blass, spoke with the ER MD; and they are trying to formulate a plan. Resident #78 will be seen by the facility□s psych services at the end of October; exact date unknown at this time. The care plan for resident #78 was updated 10/11/18 to provide structured activities for this resident. The structured activities program for this resident will attempt to alleviate behaviors and provide alternate activities for the resident; this was developed on 10/11/18. Resident was not involved with the development of this plan d/t a BIMS less than 3; and her inability to participate r/t severe cognitive impairment. We know that she will probably refuse this schedule, but we will at least attempt and document any refusals next to the activity. The Kardex has the following interventions in place: private room, 1:1 supervision and ST to evaluate; and the Certified Nursing Assistants were in-serviced on the continued use of the Kardex. New employees will be in-serviced in orientation about the Kardex. We were getting an evaluation from ST for cognition for any suggestions of cognitive related interventions. Resident #17 is one of the residents that	

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F 689	Continued From page 2 The quarterly Minimum Data Set (MDS) dated 07/11/18 indicated severe cognitive impairment for Resident #78 with supervision for activities of daily living except for dressing and personal hygiene which required extensive assistance. Resident #78 was non-ambulatory and used a wheelchair for locomotion. She exhibited verbal behavioral symptoms directed toward others on one to three days of the seven-day lookback period. Review of Resident #78 ' s care plan dated 07/12/18 revealed entries for the resident ' s psychotropic medication regime for behavior management. One of the interventions directed staff to monitor and record the occurrence of target behavior symptoms. No target behaviors were listed for Resident #78. Another nursing problem was the resident ' s need for long-term placement with ongoing review for an appropriate level of care. A review of the medical records for Residents #78, #255, #60 and #101 revealed the following significant incidents involving Resident #78 ' s inappropriate behavior: a. On 04/30/18 at 10:20 p.m. in a progress note for Resident #78, Nurse #10 documented: " ...[Resident #78] picked up the jacket [of Resident #59] and a verbal argument began. Writer asked [Resident #78] for the jacket and she handed it to the writer ...[Resident #59] continued yelling at [Resident #78]. [Resident #78] then swatted her hand at [Resident #59] and missed. [Resident #59] then swatted his hand at [Resident #78] and tapped her left arm. [Resident #78] then swatted at [Resident #59] and tapped	F 689	resident #78 inadvertently hit when she was being removed from her room. Resident #78 did not act intentionally when resident #17 was inadvertently hit; and resident #17 voiced no problems, understanding resident #78 is cognitively impaired. Resident #255 was discharged to another facility, not related to any issues related to resident #78. Resident #101 was not harmed by resident #78, but resident #78 was verbally abusive and waving an item at her. Resident # 101 has not voiced any concerns or fears with resident #78 since incident. Resident #60 was interviewed after the incident and interviewed on 10/11/18 to identify any concerns with resident #78. Resident #60 did not express any concerns of fear at this time. Resident #17, Resident #101 and resident #60 were the only three residents affected by resident #78. Resident with the potential to be affected: A. The IJ was called at 3:50pm. In-services were started on all staff at 4:00pm. All staff were in-serviced on the following: 1. Residents exhibiting challenging behaviors. 2. Monitoring changes in residents behaviors. 3. Residents safety when it comes to residents with behaviors. 4. Documentation when it comes to interventions surrounding resident to resident altercations. 5. Notifying family and DON of any changes in residents conditions. 6. Making sure that all residents incidents are recorded in risk management on an incident report. 7.	

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F 689	Continued From page 3 his right arm. Writer then stepped in between residents and moved [Resident #78] a safe distance away from [Resident #59]." An interview with Resident #59 was attempted in his room on 10/10/11/18 at 12:53 p.m. The resident's speech was not understandable. In an interview on 10/11/18 11:47 a.m., Nurse #10 explained that Resident #59 had impaired cognition and would not remember the incident that took place in April. With regard to the event, Nurse #10 stated that the jacket belonged to Resident #59. He stated that Residents #78 and #59 "just swatted at each other" during the argument. He indicated that they may have "grazed each other or just hit clothing." After he returned the jacket to Resident #59, there was no more yelling. He was able to easily redirect Resident #78. He indicated it was not necessary to notify the physician of the incident. b. On 05/12/18 at 2:15 p.m. in a progress note, Nurse #12 documented that "Resident [was] verbally and physically combative to staff because she wanted to go out to smoke. Resident hit [employee] in the chest, pushed her arms away and tried to kick her when [employee] tried to stop her from going out to smoke during nonsmoking times ..." In an interview on 10/10/18 at 10:40 a.m., Medical Records Staff #1 indicated that she was intervening to prevent the automatic double doors from closing on Resident #78 who was attempting to pass through in her wheelchair. She stated that the resident might have perceived that she was blocking her from exiting the hall and struck out at her.	F 689	How to handle demented residents. 8. Nurses ensuring that all verbal orders given by MD or NP are transcribed by receiving nurse. 9. How to access interventions from C.N.A. Kardex. 10. Reporting to appropriate people when altercations occur. The in-services were conducted by the Administrator and MDS. We in-serviced all departments □ nursing, dietary and housekeeping, agency, all staff that were in the building and department heads. Resident #78 has diagnoses of: unspecified dementia with behavioral disturbances, anxiety disorder, major depressive disorder, schizophrenia, cognitive communication deficit, which is why we did the in-service for how to handle demented residents. During this in-service, we also discussed other diagnoses with potential behaviors. B. The Executive Director and Director of Nursing held a meeting with the department heads on 10/11/18 to discuss how to identify residents with behaviors and how to protect other residents from harm. It was discussed that if a resident exhibits increased agitation that puts their roommate or others at risk, he/she will be removed from the room and started on 1:1 supervision until they can be evaluated by psych. C.MDS ran a Casper report from 8/1/2018 to 10/11/2018 to identify all residents with like behaviors to assure that the care plans are appropriate and updated if needed. D.60 days of 24 - hour reports in Point Click Care reviewed on 10/11/18 for behaviors by the Executive director,	

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F 689	Continued From page 4 c. On 08/12/18 at 4:45 p.m. in a progress note for Resident #78, Nurse #11 documented " ... [Resident #78] went into B-13 (her old room) and going through other resident ' s belongings ...Activities Director attempted to redirect resident out of room and resident hit Activities Director in her right breast ...able to remove resident from room ...Resident [#78] went back into room without staff knowing while other resident was in room. Per [Resident #255] resident [#78] open handed hit resident [#255] on left side of her face very hard with one hand and punched her in right breast chest area ...Resident [#78] removed and placed with two staff members ...MD reports to send [Resident #78] to [local hospital] via police ambulance services ..." On 08/12/18 at 7:55 p.m. in a progress note for Resident #255, Nurse #12 documented that "Resident [#255] was sitting in her room and Resident [#78] rolled up to her and slapped her on the left side of her face. Resident [#78] then punched Resident [#255] in her right breast. Resident [#78] was upset that she had been moved from that room into another room. [Attending Physician] notified of incident and gave order for 1 x [time] dose of Xanax 1 mg at bedtime per resident's request. No complaints of pain voiced by Resident [#255]." Resident #255 was unavailable for an interview because she no longer resided in the facility. In an interview on 10/12/18 at 11:42 a.m., the Activities Director indicated that her office was at the corner of the B and C Halls, the two halls where Resident #78 ' s former room and her new room were located. She stated that the resident	F 689	Director of Nursing, and Nurse Consultant. No other behaviors of similar nature noted. Systemic Changes: A.The Administrator and Director of Nursing will continue to review all 24 - hour reports Monday thru Friday during morning meeting to identify any Resident with behaviors that could be a danger to themselves or other Residents□. will QAPI x 3 months to ensure that all behaviors are identified, monitored and care planned. An Adhoc QAPI meeting was held on 10/11/18 and they were notified at this time. B.During Orientation of Licensed Nurses and Certified Nursing Assistant will be educated by the Director of Nursing or Staff Development Coordinator using Policy 51005 with Posttest □ This is the in-service on residents exhibiting challenging behaviors that all staff were in-serviced on and given a post test. C.Certified Nursing Assistants were in-serviced on reviewing Kardex daily for any new interventions for residents on 10/11/18 by MDS. D.Audit was completed by MDS, SW and the MDS Consultant on 10/11/18 and all residents identified with behaviors to assure care plan in place, individualized, and effective. These residents□ care plans were reviewed and updated with appropriate interventions as indicated. E.An Adhoc QAPI meeting was held with IDT team and Medical Director (via phone) on 10/11/18 to discuss interventions initiated and to discuss any	

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struck her when she attempted to redirect her. She denied any injury or bruising from the blow. She estimated that Resident #78 returned to her former room again within the hour and struck Resident #255. She expressed that the resident had had several room changes that she was aware of and this seemed to add to her confusion. Resident #78 used a wheelchair and propelled herself around the building.

In an interview on 10/12/18 at 4:30 p.m., Nurse #11 confirmed that she was working dayshift on the day of the incident. She stated she had worked at the facility for five years, but 08/12/18 was the first time she had been assigned to care for Resident #78. She was usually assigned to the B Hall and Resident #255. She stated Resident #78 was agitated because she could not go out and smoke unsupervised. The Activities Director mentioned to her that Resident #78 had hit her. Nurse #11 stated that she tried to keep the resident in the common hall where she could be observed. Resident #78 did not seem agitated after striking the Activities Director, and she did not assign an aide to do a one-to-one observation. Then Resident #255 came to the hall and told her she had been slapped. She told Nurse #11 that Resident #78 had simultaneously slapped and punched her. In the words of Resident #255, she "slapped her like crazy" according to Nurse #11. Resident #255 threatened that "if she comes back, I ' ll hit her." Nurse #11 indicated that Resident #255 was cognitively intact. She requested an "extra nerve pill" after the incident.

In the interview, Nurse #11 stated that she shared this information with the charge nurse on B Hall and the weekend supervisor. Nurse #11 stated

additional items recommended by Medical Director.

Monitoring:
1. Audit will be brought to the monthly QAPI meeting x 3 months by the Director of Nursing for discussion and review by the IDT team which consist of the Executive Director, Director of Nursing, MDS, Activities Director, Social Services, Maintenance, Medical Director, to assure continued compliance is maintained.

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that she did a brief assessment of Resident #255 and found no redness, no laceration or bruising of her face. She did not examine her breast/chest area. She directed Nurse #12, the charge nurse on the B Hall, to write a progress note on Resident #255. After assaulting Resident #255, Resident #78 ' s agitation had increased and a decision was made to notify Medical.

Resident #78 was evaluated at a local acute care hospital from 08/12/18 to 08/13/18. A review of the hospital discharge summary revealed that Resident #78 was seen in the Emergency Department (ED) for "aggressive behavior" on 08/12/18 at 4:36 p.m. A family member of Resident #78 was present and shared with ED staff that "normally the patient is not agitated or aggressive." She informed them that Resident #78 had not had an inpatient psychiatric hospitalization in 30 years. The resident was evaluated through telepsychiatry which determined that the resident did not meet the criteria for inpatient psychiatric admission. She was discharged to the facility the next day (08/13/18) at 12:59 p.m. There were no new orders or medication recommendations from the medical staff at the hospital.

A review of the Physician Order Summary for the month of August 2018 revealed no changes in Resident #78 ' s psychotropic medications upon her return from the hospital. Nurse Practitioner #1 at the facility wrote an order dated 08/13/18 for "CBC, CMP, UA C&S [for] behaviors, physical abuse."

d. Review of Resident #78 ' s medical record revealed that when Resident #78 returned to the facility from the hospital on 08/13/18, she was

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assigned to share a room with Resident #60 who had severe cognitive impairment.

A review of the nursing progress notes for Residents #60 and #78 revealed descriptions of their interactions during the time they were roommates (08/13/18 - 08/25/18):

On 08/14/18 at 7:50 p.m. in a progress note for Resident #60, Nurse #13 documented that "Resident [#60] has been yelling out wanting to leave room due to not comfortable with new roommate [Resident #78]. Encouraged resident to stay on her side of room and rest."

On 08/18/18 at 6:19 p.m. in a progress note for Resident #60, Nurse #14 documented that "Resident came to nurse and stated that roommate [Resident #78] told her to ' shut her G** da** mouth. ' Resident and roommate have been complaining about each other all shift."

On 08/19/18 at 7:36 a.m. in a progress note for Resident #60, Nurse #15 documented that "Resident [#60] alert and verbal, able to voice needs. Resident very upset and crying d/t [due to] roommate [Resident #78] cursing at her repeatedly. I spoke with roommate about this and got cursed out also..."

On 08/19/18 at 2:33 p.m. in a progress note for Resident #60, Nurse #14 documented that "Resident is upset with roommate [Resident #78]. Constantly stating that she can ' t stand to be in the same room as roommate. States that roommate is stealing items. Roommate was in bathroom and resident began to say ' she won ' t let me in the bathroom. ' Nurse goes to room and roommate is using the bathroom. Nurse tells

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resident "when Resident [#78] gets done using the bathroom you will be able to go in.' Resident [#60] begins to say ' no, no, she won ' t ' ...

The following notes pertain to events that occurred on 08/20/18 between Residents #60 and #78:

On 08/20/18 at 7:45 a.m. in a progress note for Resident #60, Nurse #15 documented that "Resident [#60] alert and verbal, able to voice needs. Resident very upset and crying d/t [due to] roommate [Resident #78] cursing at her repeatedly. I spoke with roommate about this and got cursed out also."

On 08/20/18 at 9:30 a.m. in a late-entry progress note for Resident #78, Nurse #13 documented that "Resident has been cursing roommate [Resident #60] and threatened to hit her with clothes hanger this morning with staff nurse asking resident to put hanger down ... Informed resident it was against policy for her to hit another person and not to use foul language with anyone ...Resident [#78] continues to curse at staff and roommate. Administrator and social worker made aware."

On 08/20/18 at 1:23 p.m. in a progress note for Resident #60, Nurse #13 documented that "Resident has been crying stating ' I ' m afraid of her [Resident #78]; she curses me and threatens me. ' (Resident is referring to roommate; social worker made aware.)"

On 08/20/18 at 3:31 p.m. in a progress note for Resident #78, Nurse #13 documented that "Resident has been cursing at roommate [Resident #60] and staff, observed resident

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waving clothes hanger at roommate with staff nurse asking the resident to put hanger down ..."

On 08/21/18 at 5:30 p.m. in a progress note for Resident #78, Nurse #13 documented that "NP [Nurse Practitioner] on rounds and made aware of recent UA C&S [urinalysis culture and sensitivity] results ...Informed NP of resident ' s behavior today also."

On 08/20/18 Nurse Practitioner #1 documented in her note that Resident #78 "continues to act out, throwing things on the floor, taking roommates ' things and swearing at staff." She wrote an order dated 08/20/18 for Augmentin Tablet 500-125 mg - give 1 tablet by mouth every 12 hours for urinary tract infection (UTI) for 7 days to start 08/21/18 and end 08/28/18.

On 08/21/18 at 9:00 a.m. in a progress note for Resident #78, Nurse #13 documented that she "Observed Resident [#78] waving a reacher stick [a handheld mechanical tool several feet long used to increase the range of a person ' s reach] near others. Staff asked resident to give to nurse; resident refused to give it to nurse or other staff cursing everyone. Resident continued to wave reacher stick around. Resident hit staff nurse with reacher stick with other nurse able to grab empty hand while staff nurse removed reacher from other hand. Resident continued to curse staff and other residents while sitting at nursing station area. Encouraged resident to go with staff to room. Resident followed staff to room. Resident transferred self to bed and rested."

On 08/23/18 at 2:13 p.m. in a progress note for Resident #78, Nurse #13 documented that "Resident [#78] has been cursing to staff and

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roommate. Encouraged resident not to use profane language. Resident continues to curse."

A census printout from the Business Office revealed that Residents #78 and #60 remained roommates on the B Hall for another two days until 08/25/18.

Nurse Practitioner #1, Nurse #14, and Nurse #15 were no longer employed at the facility and were unavailable for interviews.

In an interview on 10/10/18 at 10:00 a.m., Resident #60, who was severely cognitively impaired, remembered being threatened by Resident #78 with a clothes hanger. The resident stated she was "scared" of Resident #78 and described her as a "mean person." When asked what staff did when she told them she was uncomfortable, Resident #60 said "they told me she [Resident #78] would get better soon."

In an interview on 10/11/18 at 12:09 p.m., Nurse Aide #9 stated that the conflict between the two roommates affected Resident #60 "really badly." She shared that Resident #60 was "depressed" and would not get out of bed. Nurse Aide #9 had seen the resident cry and tell staff "I want her out of here, she ' s mean." She stated that the resident didn ' t want to eat. The aide described Resident #60 as "fussy about sticking to her routine" such as laying her clothes out the night before but Resident #78 would "mess with her things." Nurse Aide #9 was not aware of any physical threats or physical contact before the clothes hanger incident.

In an interview on 10/10/18 at 9:35 a.m., Nurse #2 on the B Hall stated she was familiar with both

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Resident #60 and Resident #78. She stated she noted a change in behavior for Resident #60 during their time as roommates. Resident #60 did not want to get out of bed and "that was not like her." She stated the resident "seemed depressed" and didn ' t want to leave her room. At one point she "felt that we need to do something" and spoke to her (former) Unit Manager (Nurse #16), the Social Worker and Admissions Coordinator.

In an interview on 10/11/18 at 12:24 p.m., Nurse #13 stated that Resident #60 would stay in the bed until Resident #78 left the room in the morning. Nurse #13 stated that Resident #60 would come and position her wheelchair close to the nurse ' s medication cart when she was working. The resident told her she felt "safer" there. Nurse #13 shared an incident in which Resident #78, who was outside the room, slammed the door on Resident #60 and would not let her come out, essentially trapping her in the room. Nurse #13 had to rescue the Resident #60 by entering the shared bathroom from the adjoining room. The nurse indicated that her main strategies for managing the conflict were talking and redirection.

Nurse #13 said that she did intervene on 08/20/18 by removing the clothes hanger from the room but there were others in the wardrobe. After Resident #78 made the threatening gesture with the clothes hanger, there was just verbal back and forth between the two for the rest of their time together, as far as she knew. Now (almost two months after sharing a room) Resident #60 refused to go down the hall if she saw Resident #78. Nurse #13 stated Resident #60 would ask her to move the resident.

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In the interview, Nurse #13 indicated that she did tell the Social Worker of Resident #78 ' s behaviors on more than one occasion. Her former Unit Manager, Nurse #16, was also aware of the conflict. She stated that she did not attend care planning meetings, just the unit managers.

In an interview on 10/11/18 at 12:34 p.m., Nurse #17 stated that Resident #60 had approached her at one point and cried out "she ' s trying to kill me, she ' s trying to kill me." Nurse #17 attempted to reassure her she was safe.

In an interview on 10/11/18 at 11:47 a.m., Nurse #10 (Unit Manager of B Hall) stated his familiarity with the conflict between Residents #78 and #60. He stated that Resident #60 received scheduled Ativan but had episodes of breakthrough anxiety above baseline during the time they were roommates. He stated that her anxiety did not develop to the point of notifying the physician. He further stated that management was aware of Resident 78 ' s inappropriate behaviors when he was hired at the end of March 2018. He indicated that he was promoted to the position of Unit Manager at the end of September. The former Unit Manager was no longer employed at the facility. As a staff nurse he did not attend interdisciplinary team meetings. Updates to resident care plans were done by the MDS Coordinators.

In an interview on 10/10/18 at 11:37 a.m., the Social Worker was not sure how she heard of Resident ' s #78 threatening behaviors. She had provided a child safety lock for Resident #60 ' s wardrobe because the nurses told her the resident was concerned about her clothes. She

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stated that the lock "made the resident feel better." She was currently engaged in seeking another placement for the resident.

In an interview on 10/10/15 at 5:15 p.m., the Administrator indicated the facility was brought under the control of a different corporation in August 2018 and a new Medical Director and Nurse Practitioner began employment on 08/27/18. She stated that when she was informed of Resident #78 ' s behaviors, she immediately instituted "frequent rounding" on the room where she and Resident #60 resided. Whoever passed by the room was instructed to look in. She confirmed that a room change was not made for another five days because she didn ' t have another room to separate the two women. There were no private rooms in the facility.

e. On 09/08/18 Resident #78 was assigned to share Room B9 with Resident #101 who had severe cognitive impairment per the MDS dated 10/03/18.

A review of the nursing progress notes for Resident #78 revealed descriptions of the interaction between the two roommates:

In a progress note for Resident #78 dated 09/10/18 at 3:00 p.m., Nurse #13 documented that "Resident {#78] has been cursing at staff and other residents today. Has taken roommate's [Resident #101] glasses and not giving back to roommate. Going through roommate's belongings."

In a progress note for Resident #78 dated 9/10/18 at 4:30 p.m., the Social Worker documented that "Behaviors escalating this late afternoon. Yelling

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at roommate, swinging arms. [Unit Manager] contacted Nurse Practitioner who provided medication order. (see orders)."

Nurse Practitioner #2 wrote an order for Resident #78 dated 09/10/18 for Ativan 0.5 mg by mouth every 8 hours as needed for anxiety and agitation to start 09/10/18 and end 09/12/18 and an order for Depakote Sprinkles Delayed Release 125 mg by mouth twice a day for major depressive disorder, severe with psychotic features, to start 09/10/18. Resident #78 had completed her course of Augmentin for a UTI on 08/28/18.

In a progress note for Resident #78 dated 09/10/18 at 5:01 p.m., Nurse #13 documented that "Resident [#78] observed by staff swinging at roommate [Resident #101] with reacher apparatus and cursing at roommate and staff. Resident was able to get roommate's eyeglasses and placed on her face. Staff able to retrieve glasses from resident to give back to roommate..."

In a progress note for Resident #78 dated 09/11/18 at 9:19 a.m., Nurse #13 documented that Ativan 0.5 mg was administered because "Resident [#78] cursing at roommate [Resident #101] attempting to go through roommate ' s closet; staff intervened."

In a progress note for Resident #78 dated 09/11/18 at 11:30 a.m., Nurse #13 documented that the Ativan was "ineffective" in helping to manage Resident #78 ' s behavior.

In a progress note for Resident #78 dated 09/11/18 at 23:00 p.m., Nurse #13 documented that "Resident ...has used profane language to

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staff and roommate [Resident #101] ...Words exchange between resident and roommate with resident becoming more agitated and started swinging reacher stick at roommate. Staff attempted to remove reacher sticks from resident. Resident swinging at staff. After resident left room on own, staff removed reacher sticks. Ativan PRN [as needed] dose given as ordered for increased agitation with results ineffective. Encouragement given to resident throughout today to end the profane language ..."

In an interview on 10/11/18 at 12:34 p.m., Nurse #17 stated that she felt that Resident #101 had declined during the time she and Resident #78 shared a room. She explained that the resident was more anxious than usual. Resident #101 told her she "couldn ' t take it." Nurse #17 stated that the resident did not want to get out of bed. She was on the window side and Resident #78 was near the door. Nurse #17 judged that Resident #101 was more intimidated than scared. The resident told Resident #78 that she "better put that [reacher grip] down or I ' ll call the police." At one point Resident #78 had collected five reacher grips before they were removed from the room. She was unable to say whether staff members did periodic checks of the room for objects with the potential to be used as a weapon. A family member had contacted the Social Worker about Resident #78 cursing at Resident #101.

In a progress note for Resident #101 dated 09/13/18 at 10:16 a.m., the Admissions Coordinator documented that "This writer went to see [Resident #101] and asked why she did not move to A7 last evening (09/12/2018) and [Resident] responded that she did not want to move to another hall because she likes her room

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B9-2, but does not care much for the roommate because of roommate ' s behaviors. This writer told [Resident #101] that we can look into other options, but [Resident #101] insisted that she does not want to be moved."

In a progress note for Resident #78 dated 09/13/2018 at 4:37 p.m., the Social Worker spoke with [family member] this evening regarding behaviors [Resident #78] is presenting toward her roommate and the need to move her to another room without a roommate. We discussed the likelihood of reaching out to memory care facilities. [The family member] expressed understanding of this."

f. In a progress note for Resident #78 dated 09/14/2018 at 9:45 a.m., the MDS Coordinator #1 documented that she "observed resident in another resident ' s room [Resident #17 ' s room] and tried to wheel resident out. Resident continued to be combative and cursing. Resident slammed the door closed and was swinging at staff and other resident. Resident hit nurse in the arm and other resident. Removed resident to safety and notified DON. Orders to send resident out due to being a threat to self and others. Called for transport to [local hospital]. Resident left by stretcher at 10:00 am. To notify MD [Medical Doctor] and RP [representative]."

In a progress note for Resident #78 dated 09/14/18 at 11:57 a.m., the Social Worker documented that "writer secured an IVC [involuntary commitment] for [Resident #78] who is now at [local hospital]. Writer advised [family member] via phone ..."

In an interview on 10/11/18 at 9:50 a.m., Resident

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#17 described the encounter with Resident #78. He was opening the door to his room and discovered Resident #78 inside. He stated that she "slammed the door in my face." He attempted to enter and she hit him on the upper arm. When asked how hard she struck him, he stated "hard enough to run and get someone." Resident #17 expressed his understanding that Resident #78 was confused. He denied any encounters with the resident since then.

The MDS dated 07/24/18 indicated that Resident #17 was cognitively intact. There was no nursing progress note for Resident #17 documenting the incident.

In an interview on 10/11/18 at 9:40 a.m., Nurse #18 confirmed she was the charge nurse on 09/14/18. She indicated that Resident #78 stayed in the hallway where staff members could observe her after the incident until the Emergency Medical Service arrived. No individual staff member was assigned. She identified Resident #17 as the resident whom Resident #78 hit. Nurse #18 stated that Resident #17 was not injured and just shrugged off the incident.

In an interview on 10/11/18 at 9:15 a.m., the MDS Coordinator #1 stated that she was attempting to move Resident #78 from Resident #17 ' s room when Resident #78 struck her and Resident #17. Residents #78 and #17 had adjacent rooms. At one point, Resident #78 was leaning forward in her wheelchair and she worried about her falling. The resident hit her with enough force to cause a five to six-inch bruise. She was in pain and went to Urgent Care for an assessment. MDS Coordinator #1 indicated that she was acting as the Interim DON during the time at the time of the

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incident. She confirmed that staff did frequent observations of Resident #78.

In an interview on 10/11/18 at 9:00 a.m., the DON confirmed that she was hired in her role on 08/27/18. She produced one incident report for Resident #78 dated 09/14/18. The DON offered that the main management strategy for the combative behaviors of Resident #78 was monitoring by frequent observation.

A review of the Discharge Summary indicated that Resident #78 was admitted 09/14/18 at 10:08 a.m. and discharged later that day at 20:44 p.m. The Physician Assistant (PA) in the Emergency Department documented her opinion that Resident #78 did not need psychiatric placement. A Nurse Practitioner in the ED recommended that Depakote 125 mg be increased from twice a day to three times a day based on a low serum level of the drug (not within therapeutic range).

In a progress note for Resident #78 dated 09/17/18 at 3:44 p.m., Nurse #16 documented that she "spoke with NP during facility visit today about [Resident #78 ' s] behaviors and the GDR [gradual dose reduction] of her Seroquel."

At the time of the survey an interview was attempted with Resident #78 in her room on 10/08/18 at 11:54 a.m. She yelled to "get the hell out of my room." On 10/08/10 at 2:01 p.m., Resident #78 was observed during a supervised smoking break. She was calm and did not display any threatening behaviors toward other residents or staff. The resident did not engage in conversation with others.

The annual MDS for Resident #78 completed

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09/19/18 recorded physical and verbal behaviors toward others, other behaviors, and rejection of care which were each present one to three days of the seven-day lookback period. Resident #78 ' s behavior was coded as "worse" compared to the prior assessment of 07/11/18. The MDS indicated that the behaviors put Resident #78 at "significant risk for physical illness or injury," others "at significant risk for physical injury," and "significantly disrupted care of the living environment."

A care plan conference for Resident #78 occurred on 09/25/18 with the Social Worker, Activities Director and MDS Coordinator #2. A family member attended by phone. The conference notes recommended to "continue with current POC [plan of care]." There were no updates to the care plan to address the resident ' s threatening and aggressive language and behaviors which had necessitated two hospital evaluations over the last two months.

Resident #78 had not been seen by the mental health specialty group since 05/23/18. She was seen by a new mental health group on 09/26/18 for evaluation of "feelings of depression and anxiety." She was considered "not appropriate for ongoing psychotherapy due to cognitive deficits."

A review of the medical record revealed a visit note dated 09/20/18 by the Attending Physician. He documented that the resident was "clinically stable with no recent significant events noted. Plan: dementia currently stable on Namenda, no signs or symptoms of depression on Trazodone and Depakote. Continue current medication regime."

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In an interview on 10/15/18 at 2:00 p.m., the Medical Director confirmed that he assumed his role on 08/27/18. He stated that he familiarized himself with residents mainly by face-to-face visits and didn ' t develop a sense of their clinical issues until usually the second visit. He explained that when he documented in his note of 09/20/18 for Resident #78 that she had "no recent significant events" with "dementia currently stable," he was primarily referring to her medical condition. He was aware that the facility had a consulting psychiatric group but that they were switching to a new provider. He stated he hesitated to refer residents to someone outside the facility because they may not know the regulations or the need for gradual dose reduction. With regards to the addition of Depakote Sprinkles Delayed Release by NP #2, the attending physician stated that nurse practitioners operate somewhat autonomously, and they may or may not feel comfortable managing psychotropic medications and judging effectiveness. He and NP #2 communicated with each other about residents. He considered the resident ' s emergency department evaluation a psychiatric consultation. He acknowledged that a resident with severe cognitive impairment would not likely benefit from psychotherapy.

In an interview on 10/12/18 at 6:15 p.m., the Administrator stated that her main strategic intervention for addressing Resident #78 ' s verbal and physical aggression was frequent observation and daily monitoring. She confirmed that Resident #78 has had no medication management since May 2018 by the mental health group following her care since May 2018. She stated that the group only saw residents for acute incidents. She stated that Resident #78 did

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have two hospital evaluations as interventions for assaultive behavior and "they were supposed to do a medication consult." The Administrator indicated that Resident #78 was not prohibited from seeing her group but, since the facility was brought under the control of the current corporation, a new preferred provider for mental health consulting was in place. She further stated that the resident was recently evaluated by the new provider but was not accepted as a candidate for psychotherapy due to dementia.

In the interview, the Administrator indicated that there were no separate interdisciplinary team meetings beside the care planning meetings that take place every three months at a minimum. Care plans were then updated with new information. She stated that the facility did not have private rooms, but Resident #78 was currently assigned a room without a roommate in order to minimize her intrusive and at times aggressive behavior. The Social Worker was searching for a more appropriate placement for Resident #78.

2. The Administrator was informed of the Immediate Jeopardy on 10/11/18 at 3:50 p.m. On 10/12/18 at 4:30 p.m., the facility provided the following credible allegation of immediate jeopardy removal:

"Resident Affected:

Resident #78 was moved to a private room on 9/13/18 to decrease agitation and will remain in a private room. Resident was placed on 1:1 supervision while awake. Resident ' s 1:1 was started 10/11/18 at 4:00 p.m. and will continue until the resident is evaluated by Psych. We will

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provide 1:1 for seven days and then re-evaluate resident ' s status. The resident has been sent to a local hospital today, 10/12/18, for psych evaluation related to continued agitation. The resident ' s MD was contacted to address continued agitation and orders obtained to send the resident to ER [Emergency Room] for continued agitation. The Medical Director spoke with the ER MD, and they are trying to formulate a plan. Resident #78 will be seen by the facility ' s psych services at the end of October; the exact date is unknown at this time. The care plan for resident #78 was updated 10/11/18 to provide structured activities for this resident. The structured activities program for this resident will attempt to alleviate behaviors and provide alternate activities for the resident; this was developed on 10/11/18. The resident was not involved with the development of this plan due to a BIMS [Brief Interview for Mental Status] less than 3 and her inability to participate related to severe cognitive impairment. We know that she will probably refuse this schedule, but we will at least attempt and document any refusals next to the activity. The Kardex has the following interventions in place: private room, 1:1 supervision and ST [Speech Therapy] to evaluate. Certified Nursing Assistants were in-serviced on the continued use of the Kardex. New employees will be in-serviced in orientation about the Kardex. We were getting an evaluation from ST for any suggestions of cognitive-related interventions.

Resident #17 is one of the residents that Resident #78 inadvertently hit when she was being removed from her room. Resident #78 did not act intentionally when Resident #17 was inadvertently hit and Resident #17 voiced no

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problems, understanding Resident #78 is cognitively impaired. Resident #255 was discharged to another facility, not related to any issues related to Resident #78. Resident #101 was not harmed by Resident #78, but Resident #78 was verbally abusive and waving an item at her. Resident #101 has not voiced any concerns or fears with Resident #78 since incident. Resident #60 was interviewed after the incident and interviewed on 10/11/18 to identify any concerns with Resident #78. Resident #60 did not express any concerns of fear at this time. Resident #17, Resident #101 and Resident #60 were the only three residents affected by Resident #78.

Residents with the potential to be affected:

A. The Immediate Jeopardy was called at 3:50 p.m. In-services were started for all staff at 4:00 p.m. All staff were in-serviced on the following:

1. Residents exhibiting challenging behaviors,
2. Monitoring changes in residents ' behaviors,
3. Residents ' safety when it comes to residents with behaviors,
4. Documentation when it comes to interventions surrounding resident-to-resident altercation,
5. Notifying family and DON of any changes in residents ' conditions,
6. Making sure that all residents ' incidents are recorded in risk management on an incident report,
7. How to handle residents with dementia,
8. Nurses ensuring that all verbal orders given by the MD or NP are transcribed by the receiving nurse,
9. How to access interventions from CNA [Certified Nursing Assistant] Kardex, and

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F 689	Continued From page 24 10. Reporting to appropriate people when altercations occur. The in-services were conducted by the Administrator and MDS. We in-serviced all departments - nursing, dietary, housekeeping, agency, all staff that were in the building, and department heads. Resident #78 has diagnoses of unspecified dementia with behavioral disturbances, anxiety disorder, major depressive disorder, schizophrenia, and cognitive communication deficit, which is why we did the in-service for how to handle residents with dementia. During this in-service, we also discussed other diagnoses with potential behaviors. B. The Executive Director and Director of Nursing held a meeting with department heads on 10/11/18 to discuss how to identify residents with behaviors and how to protect other residents from harm. It was discussed that if a resident exhibited increased agitation that puts their roommate or others at risk, he/she will be removed from the room and started on 1:1 supervision until they can be evaluated by psych. C. MDS ran a CASPER report from 08/01/18 to 10/11/18 to identify all residents with like behaviors to assure that the care plans are appropriate and updated if needed. D. Sixty days of 24-hour reports in Point Click Care were reviewed on 10/11/18 for behaviors by the Executive Director, Director of Nursing and Nurse Consultant. No other behaviors of a similar nature were noted. Systemic Changes:	F 689		

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A. The Administrator and Director of Nursing will continue to review all 24-hour reports Monday through Friday during morning meetings to identify any resident with behaviors that could be a danger to themselves or other residents and will QAPI [Quality Assurance and Performance Improvement] for three months to ensure that all behaviors are identified, monitored and care planned. An ad hoc QAPI meeting was held on 10/11/18 and they were notified at this time.

B. During orientation Licensed Nurses and Certified Nursing Assistant will be educated by the Director of Nursing or Staff Development Coordinator using Policy 51005 with posttest. This is the in-service on residents exhibiting challenging behaviors that all staff were in-serviced on and given a posttest.

C. Certified Nursing Assistants were in-serviced on reviewing the Kardex daily for any new interventions for residents on 10/11/18 by MDS.

D. An audit was completed by MDS, the Social Worker and the MDS Consultant on 10/11/18 for all residents identified with behaviors to assure a care plan was in place, individualized, and effective. These resident care plans were reviewed and updated with appropriate interventions as indicated.

E. An ad hoc QAPI meeting was held with the interdisciplinary team [IDT] and Medical Director (via phone) on 10/11/18 to discuss the interventions initiated and to discuss any additional items recommended by the Medical Director.

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Monitoring:

The audit will be brought to the monthly QAPI meeting for three months by the Director of Nursing for discussion and review by the IDT team (which consists of the Executive Director, Director of Nursing, MDS, Activities Director, Social Services, Maintenance, and Medical Director) to assure continued compliance is maintained."

The Administrator will be responsible for implementing and evaluating the plan of correction.

Immediate Jeopardy was removed on 10/12/18 at 7:00 p.m. when validation of the credible allegation for Immediate Jeopardy removal was completed by the following review:

The in-service on residents exhibiting challenging behaviors was provided on 10/11/18. Staff members were given a posttest on the training material. The training document showed that the following topics were included:

1. The need to notify the Administrator and DON when residents are involved in altercations,
2. The need to notify the family and DON of any changes in resident ' s condition,
3. The need to complete an incident report and enter the incident in the Risk Management system,
4. The need to ensure residents ' safety following an altercation,
5. The need to monitor changes in resident behaviors, and
6. The need for nursing screening.

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F 689	Continued From page 27 The 24-hour report process was reviewed. A determination of other residents affected by behavior in the past 60 days was done by management. The inclusion of structured activities in the care plan of Resident #78 was verified. A Quality Assurance meeting was held to discuss current residents with behaviors and the screening process for newly admitted residents using the care plan audit tool. A Behavior Care Plan Audit tool was developed to identify residents at risk for challenging behaviors, to review and assess care planning as appropriate, to revise care plans when needed, and to initiate a baseline care plan for newly admitted residents within 48 hours. Management review of the CASPER report of quality levels for residents with behavior issues was done and care plan updates for identified residents were completed and verified. Validation: Immediate Jeopardy (IJ) was removed on 10/12/18 when validation was completed of the credible allegation for IJ removal as evidenced by interviews conducted on with staff members to verify that they had received re-education regarding resident-to-resident altercations, appropriate actions to be taken for residents with aggressive behaviors, and abuse policies and procedures.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		10/30/18

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F 761	Continued From page 28 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove 17 packs of expired Nutri Source Fibers and 4 plastic containers of Vitamin E from 2 of 2 medication storage rooms on A and B halls. Findings Included: 1. On 10/9/18 at 8:55 AM, during the observation of the medication storage room on B-hall with Nurse #10, there were 17 packs of Nutri Source Fibers, 4 g (gram) each, expired by 4/26/18. 2. On 10/9/18 at 9:05 AM, during the observation	F 761	F-761 This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) Interventions for affected resident: There were no residents affected expired	

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F 761	Continued From page 29 of the medication storage room on A-hall with Nurse #10, there were 4 plastic containers of Vitamin E, 100 Soft gels 400 International Units each, expired in August 2018. On 10/9/18 at 9:15 AM, during an interview, Nurse #10 indicated that medication room supplier checked the expiration date while restocking the medication storage rooms. He mentioned that all the nurses should check the expiration date on medications in the storage room. On 10/9/18 at 11:15 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to check all the medications. Her expectation was that no expired items be left in the medication carts or in medication storage rooms.	F 761	medications (Vitamin E and Fiber Source packets) removed from medication room and disposed of properly. 2) Interventions for residents identified as having potential to be affected: Current resident have the potential to be affected. Medication rooms were inspected using the Medication Room Audit tool. There were no other residents affected. Current licensed nursing staff were educated by the DNS on Medication Storage Using the Medication Storage Policy and Procedure. 3.) Systemic Change Current Licensed Nursing staff will be educated on Medication Storage using the Medication Storage Policy and Procedure and Post test. The Unit Managers and License Nurses will audit the medication rooms Monday - Friday X4 weeks, then biweekly x 1 month, then monthly X2 months. The audits will be brought to Clinical Morning Meeting to be reviewed by the IDT team which consists of the DON, Executive Director, Unit Managers, Social Worker, and MDS Nurse. Newly hired staff will be given training and education on nail care procedure upon hire with orientation. Monthly QA Committee Meeting will be conducted to review and discuss the facilities adherence to the monitoring of the above concerns as well as any other concerns brought forth. 4.) Monitoring of the change to sustain system compliance ongoing: The Executive Director will report the audit findings to the QA committee	

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F 761	Continued From page 30	F 761	monthly for 4 months. The QA committee will review the audits and ensure compliance is ongoing and determine the need for further audits/ re-education beyond the period of three months.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to provide an adaptive cup for fluid consumption during meals for 1 of 1 resident reviewed for special eating equipment (Resident # 39). Finding included: Resident #39 was readmitted to the facility on 8/7/17. Her diagnoses included: dysphagia, hemiplegia and hemiparesis following cerebrovascular disease affecting left non dominant side, Parkinson disease, dementia and major depression. Review of speech therapy transition evaluation and plan of treatment dated 6/15/18 revealed long term goal for Resident #39 indicated to utilize compensatory strategies with optimum safety and efficiency of swallowing function during by mouth food intake without overt signs and symptoms of aspiration. Short term goals indicated Resident#39 will swallow thin liquids using compensatory strategies and adaptive equipment as indicated and display no overt signs	F 810	F-810 This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) Interventions for affected resident: Current residents have the potential to be affected, no other residents, other than #39, were identified as being affected. A. 1. The Director of Nursing ensured that resident #39 was provided the appropriate adaptive equipment. B. 1. The Rehab Manager and Director of	10/30/18

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F 810	Continued From page 31 and symptoms of aspiration. Review of diet order dated 6/18/18 read in part "Regular diet, Mechanical Soft texture, Regular - Thin consistency - NO straws thin liquids in Provale cup". Review of the most recent quarterly Minimum Data Set (MDS) dated 08/10/18 revealed Resident #39 was assessed as having cognitively impaired. Resident #39 was assessed needing supervision during eating and on mechanically altered diet. Review of care plan updated on 8/13/18 revealed Resident #39 was care planned for nutritional risk related to mechanically altered diet due to aspiration. Goals indicated Resident #39 will have no injuries and choking related to aspiration. Interventions included informing all staff of resident's special dietary and safety needs. Diet to be provided as prescribed and referring to speech therapy as needed. Observing and reporting any signs of dysphagia including coughing, chocking and pocketing. Resident # 39 was also care planned for swallowing and dentures. The goals were reasonable and measurable, interventions were appropriate. During an interview on 10/8/18 at 12:30 PM, Resident #39's family member indicated the staff did not provided the special cup for drinking the fluids. Family member further indicated the staff did not fill the cup with the beverages when the special cup was provided on the tray. Family member stated Resident # 39 was an aspiration risk as the resident constantly coughs and chokes during meals. An observation of Resident# 39 lunch tray on 10/8/18 at 12:39 PM revealed no provale cup (a cup designed to small swallow, predetermined volume of thin liquids in a normal drinking motion) on the tray. Resident #39 was offered ice tea for	F 810	Nursing in-serviced Cooks, Dietary Aides, MDS, Rehab, CNAS and licensed nurses on 10/18/18 regarding appropriate adaptive equipment for residents. 2. The Rehab Manager and Culinary Manager did a house wide audit of all residents requiring adaptive equipment and provided an updated list to the Executive Director, Director of Nursing and MDS. This list will be updated weekly at Standards of Care meeting by the Rehab Manager. 3. MDS ensured that residents requiring adaptive equipment have an appropriate care plan in place. 4. MDS will ensure that the appropriate adaptive equipment are on the C.N.A.S. Kardex. 2) Interventions for residents identified as having potential to be affected: Cooks and Dietary Aides were in-serviced using the policy and procedure on labeling and dating procedures, storage guidelines, on 10/19/18 by the Culinary Manager. Staff Signatures were collected to ensure staff acknowledgment utilizing policy and procedure with a posttest to ensure compliance and competency. Newly Hired staff will be educated on correct storage, labeling and dating of food items using policy and procedure on food labeling and storage. 3.) Systemic Change Using audit tool the Culinary Manager will ensure that residents have the appropriate adaptive equipment on the	

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F 810	Continued From page 32 her lunch on her tray. Resident #39 was also offered a cup of coffee after the tray was set up for the resident. Resident did have weighted spoon and weighted fork on her tray. Review of the meal ticket for lunch on 10/8/18 at 12:42 PM for Resident # 39 revealed, beverages milk, coffee or tea. Weighted spoon, weight Fork, 10 cubic centimeter (cc) Provale cup. During an observation on 10/09/18 at 08:00 AM, Resident #39 was served breakfast tray by the staff. The tray consisted of a milk carton and 8-ounce (oz) cup of orange juice for beverages. Observation revealed the tray did not consist of the provale cup. Observed NA #1 serve the resident coffee in a regular cup and serve the glass of orange juice in a regular glass. During an interview with on 10/09/18 at 08:04 AM, NA#1 indicated she was not sure what the 10 cc Provale cup indicated on the tray card was. NA #1 stated the cup was something the nurse would provide during her medications. During an interview with NA # 2 on 10/09/18 at 08:06 AM, NA #2 stated any special cup used by the resident was provided by the nurse as it was available on the nursing cart. NA #2 indicated she was unaware what the cup was for. During an interview on 10/09/18 08:10 AM, Nurse #1 indicated any special dinning utensils or equipment indicated on the tray card were provided by the dietary services. Nurse #1 indicated the nursing cart does not carry any dietary indicated utensils. During an observation on 10/09/18 at 08:14 AM, observed Nurse #1 bring the provale cup from the kitchen and poured the remaining half cup of the orange juice into it. Nurse #1 stated the provale cup should be provided on the meal tray and NA's should poured beverages into it, so that the resident could drink juice or any beverages	F 810	tray prior to giving to resident 5 days a week for 4 weeks, then bi weekly x1 month, then monthly x 2 months to ensure compliance and identify area of improvement as needed. Newly hired staff will be educated on appropriate adaptive equipment for residents requiring them. The Executive Director or Director of Nursing will make weekly rounds to ensure that residents have the appropriate adaptive equipment weekly for 4 weeks, then monthly x3 months to ensure compliance. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the Dietary audits monthly for a minimum of four months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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F 810	Continued From page 33 without any aspiration risk. During an interview on 10/10/18 10:12 AM, Speech Therapist (ST) stated Resident #39 has Parkinson's and dysphagia. ST stated she had worked with the resident related to cognition and swallowing techniques. ST stated the provale cup was provided to control the rate of fluids to swallow and to prevent risk of aspiration. ST stated it was her expectation that the resident was provided with the provale cup during meals for consuming her fluids. ST indicated it was provided by the dietary on the tray. ST stated the resident was supposed to be supervised at meals, sitting upright in bed to prevent any aspiration risk and cued to tuck her chin for swallowing. During an interview on 10/11/18 09:19 AM, Director of Nursing indicated it was her expectation all residents were provided the appropriate equipment as indicated for safe dinning. She also indicated staff needs to be educated on resident needs, where to get the equipment and how to use the equipment for safe dining techniques.	F 810		
F 812 SS=E	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	F 812		10/30/18

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F 812	Continued From page 34 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 and staff interviews, the facility failed to properly label foods in the kitchen ' s walk-in refrigerator and walk-in freezer and discard expired food in the kitchen ' s dry storage and the walk-in refrigerator. Findings included: Observations of foods stored in the kitchen ' s dry storage area, walk-in refrigerator and walk-in freezer from 10:25 a.m. to 10:45 a.m. revealed the following concerns with food storage: a. In the kitchen ' s dry storage area a container of baking soda with a typed label of "Dry storage 05/08/17, expires 11/08/17." b. In the kitchen ' s walk-in refrigerator a large opened plastic container with a commercial label of "sweet and sour sauce" was dated "07/04/18" written in marker. c. In the kitchen ' s walk-in refrigerator a clear plastic package was labeled "deli meat, 09/17/18." d. In the kitchen ' s walk-in refrigerator a clear plastic package with a date of "10/02/18" written in marker. The Dietary Manager identified the	F 812	F-812 This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) Interventions for affected resident: Current residents have the potential to be affected, no residents were identified as being affected. A. 1. The Culinary Manager discarded the container of baking soda 10/8/18. 2. The Culinary Manager discarded the sweet and sour sauce on 10/8/18. 3. The Culinary Manager discarded the deli meat on 10/8/18. 4. The Culinary Manager discarded the sliced cheese on 10/8/18. 5. The Culinary Manager discarded the shredded mozzarella cheese on 10/8/18. 6. The Culinary Manager discarded the chicken tenders on 10/8/18. .	

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	345227	A. BUILDING _____ B. WING _____	C 10/12/2018

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F 812	Continued From page 35 food as sliced cheese. e. In the kitchen ' s walk-in refrigerator a clear plastic package of opened shredded mozzarella cheese with a date of "5/15" written in marker. The original packaging inside listed a "Use by Aug 10 18" date. f. In the kitchen ' s walk-in freezer a clear plastic package dated "10/07/18." The Dietary Manager identified the food as "chicken tenders." In an interview on 10/08/18 at 11:40 a.m., the Dietary Manager acknowledged that the labeling and dating of items was inconsistent and that some expired items had not been discarded. She stated that food should be labeled when removed from the vendor box to identify what was in the package. The dates listed on the walk-in refrigerator items (deli meat, sliced and shredded cheeses) were the dates they were removed from the freezer. She indicated that the current policy was to use condiments within one month and frozen items within seven days of thawing. She stated that dates of labeled items were checked at the beginning and end of each shift. All kitchen aides knew to check for expired items. The Dietary Manager stated that she did spot checks and would check when she loaded vendor items in the freezer and dry storage. If she identified an issue, she stated that she did a short in-service with the kitchen staff. In an interview on 10/12/18 at 9:40 a.m., Dietary Aide #1 stated that when she removed food from the freezer she labeled the item with the date thawed and a use-by date of one day if thawed for a meal. She indicated that everyone was responsible for checking the refrigerator and	F 812	B. 1. The Culinary Manager in-serviced Cooks and Dietary Aides on 10/8/18 regarding food storage/labeling policies. 2) Interventions for residents identified as having potential to be affected: Cooks and Dietary Aides were in-serviced using the policy and procedure on labeling and dating procedures, storage guidelines, on 10/8/18 by the Culinary Manager. Staff Signatures were collected to ensure staff acknowledgment utilizing policy and procedure with a posttest to ensure compliance and competency. Newly Hired staff will be educated on correct storage, labeling and dating of food items using policy and procedure on food labeling and storage. 3.) Systemic Change Using audit tool the Culinary Manager or Cook on duty will randomly audit for correct storage, labeling and dating in refrigerators, freezers, storage areas and supply rooms 5 days a week for 4 weeks, then biweekly x1 month, then monthly x 2 months to ensure compliance and identify area of improvement as needed. Each Audit will cover correct storage, labeling, and dating for all refrigerators, freezers, kitchen storage areas, and the dry food storage room. Newly hired staff will be educated on the policy and procedure of correctly labeling and dating, as well as, appropriate food storage. The Executive Director or Director of Nursing will make weekly rounds with the	

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F 812	Continued From page 36 freezer for expired foods that need discarding. In an interview on 10/12/18 at 2:34 p.m., the Administrator shared her expectation that all foods were labeled appropriately to ensure safety and that staff members immediately discard expired items.	F 812	Culinary Manager to observe kitchen and dining room to monitor for correct labeling, dating and appropriate storage, weekly for 4 weeks then monthly 3 months to ensure compliance. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the Dietary audits monthly for a minimum of four months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, the facility ' s Quality Assessment and Assurance Committee(QAA) failed to maintain implemented procedures and monitor interventions that committee put into place following the 8/12/17 recertification survey. The recited deficiency was in the area of Drug Storage, Label/Storage Drugs and biologicals. The findings included: The F761 tag is cross referenced:	F 867	F-867 This plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) Interventions for affected resident:	10/30/18

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F 867	Continued From page 37 Based on observations and staff interviews, the facility failed to remove 17 packs of expired Nutri-Source Fibers and 4 plastic containers of Vitamin E from 2 of 2 medication storage rooms on A and B halls. During an interview on 10/12/18 at 3:20 PM, the Administrator indicated the facility was currently working with QAA and QAPI committees to improve the monitoring of medication storage process. The administration further stated the Corporate Operation Director would be creating the plan of correction and monitoring schedule with staff member, responsible for it implementation of this process. This process would be monitored by the corporate office in biweekly-monthly timeframe.	F 867	There were no resident affected by this practice. The expired medications were disposed of properly and MD was notified. There was no additional orders given by the MD at this time. 2) Interventions for residents identified as having potential to be affected: A QAPI meeting was held on 10/18/18 to discuss expired medications in the medication room and ensuring accuracy of medications by the QAPI committee which consist of ED, DON, MDS, Nurse Managers, Activities Coordinator, Social Worker, BOM, Medical Director and Pharmacy Rep. QAPI will review the audits for completeness of medication room review, removed and destruction of expired medications. 3.) Systemic Changes A weekly QAPI meeting will be held for a period of four (4) weeks then Monthly to review and discuss the facility adherence to the monitoring of expired medications. The Unit Managers will perform audits on the Medication Room expired medications process weekly x 4 weeks, then biweekly x1 month, then monthly x 2 months. Education will be provided to the Licensed Nurses, Unit Managers and Central Supply by the Director of Nurses and the Nurse Consultant to review medication rooms for expired medications. The audit will continue to be a part of the education process for current staff and newly hired members of the IDT team upon orientation. 4.) Monitoring of the change to sustain system compliance ongoing:	

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F 867	Continued From page 38	F 867	The Executive Director will report the audit findings to the QA committee monthly for 4 months. The QAPI committee consists of ED, DON, MDS, Nurse Managers, Activities Coordinator, Social Worker, BOM, Medical Director and Pharmacy Rep. QAPI to ensure compliance is ongoing and determinate the need for further audits.	