STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY REHAB AT NORTHMOOR	**1500 WEST NORTHMOOR ROAD PEORIA, IL 61614**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to verify the resident's chosen Advance Directive for resuscitation and failed to ensure the medical record contained the accurate Advanced Directive for one of two residents, (R41) reviewed for Advanced Directives in the sample of 30. Findings include: The facility's Policy For Advance Directives, dated [DATE], documents the following: This Facility recognizes the dignity and value of each Resident's life and the right of each Resident to make decisions regarding his or her care. R41's current medical record includes a POLST (Practitioner Order for Life-Sustaining Treatment) Form, dated [DATE] and signed by R41's Power of Attorney, documents the choice for Full Code Status. Full Code Status indicates that CPR (Cardio-Pulmonary Resuscitation) is to be attempted in the event R41 experiences cardio-pulmonary arrest. R41's [DATE] POS (Physicians Order Sheet), documents R41's Advance Directive order as Do Not Resuscitate (DNR). DNR indicates that no cardio-pulmonary resuscitation efforts will be employed in the event R41 experiences cardio-pulmonary arrest. On [DATE] at 2:55 PM, V2, DON (Director of Nursing), verified R41's POLST Form documents R41's Advance Directive is for a Full Code and R41's current POS document his Advance Directive as Do Not Resuscitate and is in error.
F 0688 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a ROM (Range of Motion)/Restorative program to prevent a decline in ROM for two of five residents (R42, R49) reviewed for ROM limitations in the sample of 30. This failure resulted in R42 and R49 experiencing a a decrease in Functional Range of Motion. Findings include: The facility's Restorative Nursing Programs policy, dated 12/1/16, documents, It will be the standard of this facility to provide restorative nursing services to residents that require them to attempt to maintain or improve function or as ordered by the physician. The therapy/rehab department will conduct routine screens on residents to ensure there has not been a decline in function. In the event that a change is present, it is appropriate for the resident to receive therapy or restorative programs to attempt to maintain or improve highest practicable level of care. 1. On 3/08/20 at 10:18 AM, R49 had ROM limitations of her bilateral shoulders; unable to reach up to her head, left leg unable to bend at the knee, and right leg stiff with movement. R49 denied doing exercises with staff on a regular basis. On 3/10/20 at 2:21 PM, V18 and V19 (Both Certified Nursing Assistants-CNA) transferred R49 from her high back reclining wheel chair to her bed using a mechanical lift and total assist of both staff members. V18 stated that R49 is not on a restorative program for her ROM deficits. V18 also stated that R49 broke her left leg during a one person assist transfer with a CNA and now she's a total mechanical lift assist because of it. On 3/10/20 at 3:00 PM, R49 stated, I do not get exercises on a daily basis, and I really wish I could. My joints are tight and I can't even bend my left knee. After my knee fracture healed up all the facility did was take the brace off. I haven't even been able to attempt to stand up. I always have to use the mechanical lift. R49's X-ray report, dated 8/12/19, documents that R49 has an acute tibial tubercle avulsion fracture. R49's Fall care plan, dated 10/28/19, documents an intervention on 8/9/19 following her fall for a transfer program to be implemented once R49's left tibia fracture is healed. R49's MDS, dated [DATE], documents that R49 has functional ROM limitations to R49's bilateral upper and lower extremities and in Section O Special Treatments, Procedures, and Programs that R49 is not on a restorative and/or ROM program. R49's Contracture Assessment, dated 2/4/20, documents that R49 has ROM functional limitations with pain to her bilateral shoulders and hips. R49's physician's orders [REDACTED]. On 3/11/20 at 8:44 AM, V1 (Administrator) stated that R49 was not on any ROM/restorative programs. On 3/11/20 at 9:47 AM, V7 (Care plan coordinator) stated, R49's weak hip flexors, right and left leg contractures, and bilateral shoulders are tight and unable to reach completely above her head is the reason why she is coded as bilateral upper and lower ROM limitations. When R49 fell and broke her left tibia/fibia she was a one assist turn and pivot transfer. With the fracture she was switched to a mechanical lift, and the plan was to initiate a transfer restorative program once the fracture was healed. We were going to initiate this program to strengthen her legs, but since they took away the restorative nurse, the program was never initiated. Now, R49 is still a mechanical lift even though the fracture is healed. I have fought and fought for this but I've gotten nowhere. 2. On 3/8/2020 at 11:30 AM, R42 was able to propel his own wheelchair using upper and lower extremities with some resistance to upper extremities. On 3/9/2020 at 8:30 AM, R42 was sitting in the wheelchair. R42 was not able to raise his arms above his shoulders. R42 stated, No, I cannot do that (raise arms above his shoulders), and I am not getting my exercises. R42's Rehab Restorative Assessments, dated 9/11/2019, 11/11/19, and 1/14/20, document, Overall physical condition: Poor posture, poor endurance, due to muscle weakness. Limited ROM (Range of motion) to hips and right shoulder. Rehab Restorative Program Recommendations: Active Range of Motion Exercises up to 7 days per week for the following: UE/LE (Upper extremities/Lower extremities) strengthening and ROM (Range of Motion) to maintain/improve joint ROM (Range of motion) and muscle strength. R42's MDS (Minimum Data Set), dated 12/13/2019, documents in Section G Functional Status that R42's Functional Limitation in Range of Motion, is coded a 2/2, which indicates ROM (Range of Motion) impairment in R42's bilateral upper and lower extremities. R42's MDS also documents in Section O Special Treatments, Procedures, and Programs that R42 is not receiving any ROM/Restorative programs. R42's Care plan, dated 2/22/2020, documents, R42 has bilateral knee instability that is related to [MEDICAL CONDITION]. R42's current medical record has no documentation of R42 receiving any ROM/Restorative programs for R42's ROM limitations. On 3/10/2020 at 10:00 AM, V7, CPC (Care plan Coordinator), stated, Based on my clinical observation and assessment, R42 was not able to perform full ROM to R42's bilateral upper and lower extremities. R42 cannot get his arms up above his shoulders, and R42 has weak lower extremities due to his weak hip flexors. On 3/10/2020 at 10:10 AM, V7, CPC (Care plan Coordinator), verified that R42's Rehab Restorative Assessment recommended that R42 be on a ROM/Restorative program, however, R42 is not on a ROM/Restorative program
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview, and record review, the facility failed to properly transfer a resident and implement fall interventions following the identification of a fracture for one of two residents (R49) reviewed for falls in the sample of 30. Findings include: The facility's Event/Incident Reporting and Documentation policy, dated 1/1/14, documents, All Events/Incidents will be investigated to determine cause of the event, any witnesses to the event, and any corrective or proactive actions that need to be made to prevent or lessen another event from occurring. The policy also documents, Once the investigation and analysis is completed, all proactive or corrective actions will be reviewed by the team to ensure that the resident's plan of care is appropriate and revisions have been made. The facility's Fall policy, dated 6/[DATE]8, documents, Based on evaluation of an existing fall (s) pertinent interventions will be implemented by staff such as, but not limited to: resident education if appropriate, staff re-education regarding transfer techniques and safety during ADL (Activities of Daily Living) care. On [DATE] at 2:21 PM, V18 and V19 (Both Certified Nursing Assistants-CNAs) transferred R49 from her high back reclining wheel chair to her bed using a mechanical lift and total assist of both staff members. V18 stated that R49 broke her left leg during a one person assist transfer with a CNA and now she's a total mechanical lift assist because of it. R49's Fall Risk assessment, dated 10/15/19, documents that R49 is at a significant risk for falls. On [DATE] at 3:00 PM, R49 stated, I fell twice that weekend. The first one (8/9/19) was my fault 110% when I tried to get up on my own. The second one is when I fell with the CNA. R49 also stated, My joints are tight and I can't even bend my knee. After my knee fracture healed up all they did was take the brace off. I haven't even been able to attempt to stand up I always have to use the mechanical lift. R49's Incident/Accident Report, dated 8/9/19, documents, R49 observed sitting on foot pedals (of wheel chair) watching television. R49's Incident/Accident Report, dated 8/12/19, documents, R49 complained of increased pain to R49's left hip and left lower extremity. Bruising and swelling observed to area just below knee. R49 unable to straighten leg without yelling out in pain. R49's Pain Assessment that was completed with this report, documents that R49 is complaining of pain with the indicators of gasping, groaning, becoming non-verbal, grimacing, wrinkled brow, guarding, resistive to cares, irritable, decreased ADL (Activities of Daily Living) activities, and verbal complaints of, No/stop, that hurts, screaming, and asking for medications. The pain assessment also documents that the pain was a sudden onset of pain a few days ago when her leg started hurting really bad, and the pain affects her ability to sleep, limits day to day activities, and mood. The facility's Investigation Report, dated 8/15/19, documents, R49 complained of pain to left hip. Upon assessment, swelling to and slight discoloration noted. R49 stated that upon transfer with V17 (CNA), R49 accidentally applied weight to left side instead of right side. Summary of Interview with resident: R49 stated that V17 was transferring her from the bed to her high back reclining wheel chair. R49 stated that she applied her full weight onto her left leg, 'the bad leg,' instead of the right leg. The report also documents, Investigation findings indicate that R49 has a history of a fracture to her left leg. R49 states that she stepped down and put full body weight on the left leg instead of the right as previously instructed during a transfer. A documented phone interview with V17, dated 8/15/19 and signed by V2 (Director of Nursing), documents that V17 transferred R49 and when the transfer was complete R49 was complaining of leg pain. On [DATE] at 1:48 PM, V2 (Director of Nursing) stated, On 8/9/19, R49 was found on the floor sitting on her high back reclining foot pedals. A male CNA (who no longer works here) found her when she was yelling out to him. R49 had chronic pain and complained of pain on a regular basis, so according to staff her pain level had not changed in result of the fall. On [DATE], V17 (CNA who no longer works here) transferred (R49) from her bed to the high back reclining wheel chair, and said that during the transfer R49 yelled out 'Ouch!' V17 then brought R49 to the nurses desk to see if R49 had pain medicine recently, but did not report (R49) yelling out during her transfer. V17 also noted a bruise on R49's left lower leg that she did not report. The following morning, the nurses noted the bruising, swelling, and increased pain and notified the doctor. The x-ray was positive for a fracture in R49's left lower leg so she ordered to send her to the emergency room . When I interviewed R49 she stated that during a transfer with V17, (R49) accidentally put her weight on her 'bad' left leg instead of her right. In my investigation, the time spans were to close of the fall on 8/9/19 and the transfer on [DATE] to determine if it was the fall or transfer that caused the fracture. On 3/11/20 at 12:16 PM, V2 (Director of Nursing) stated, I did education with the staff after the fracture was discovered because V17 did not immediately report to the nurse that R49 yelled out in pain during the transfer on [DATE], instead it wasn't reported until 8/12/19. This was a change in R49's pain especially if she yelled out in pain with the transfer. According to the interviews I did during the investigation, V17 transferred R49 improperly when she pivoted on the wrong leg. R49's transfer technique instructions would have been in R49's room on her plan of care that hangs on their closet door. So, V17 should have known the proper way of transferring R49. I can not provide this document because I don't know where it is at this time. With the conclusion of my investigation I was unable to determine the cause of the fracture, but I didn't put any new intervention in place following my investigation to prevent a fracture from happening again. R49's Fall care plan, dated 10/28/19, documents, R49 has been assessed and identified to be at risk for falls. R49's care plan has no documentation of an intervention implemented following R49's fall, improper transfer, and identification of a fracture.
F 0698 **Level of harm -** Actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders [REDACTED]. This failure resulted in R14 being hospitalized and receiving emergency [MEDICAL TREATMENT] treatments. FINDINGS INCLUDE: The facility policy, [MEDICAL TREATMENT], dated (revised) 12/2017 directs staff, It will be the standard of this facility to provide the necessary care and services to those residents receiving [MEDICAL TREATMENT] while a resident at the facility. Once admitted , the facility will verify orders for [MEDICAL TREATMENT], location and times per week in order to secure transportation to the [MEDICAL TREATMENT] center to avoid disruption in service. Once the hospital transfer discharge paperwork/orders has been received the nurse will verify all orders with the physician for accuracy of medications, diet, treatments and any fluid restrictions. If the resident has orders for fluid restriction, they should be clarified as to which shift provides which amount of fluid per shift between nursing and dietary services. Resident's intake and output will be required to be recorded only with a physician's orders [REDACTED]. (R14's) Facility Inquiry Quick Admit Worksheet, dated 11/18/19, documents,[MEDICAL TREATMENT]: T/T/Sa (Tuesday, Thursday and Saturday) at 1:00 P.M., Downtown. Signed up for (local bus service) for [MEDICAL TREATMENT]. R14's (facility) Face Sheet documents that R14 was admitted to the facility on [DATE]. R14's Physician order [REDACTED]. This same document includes the following physician orders: [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday at 1:00 P.M.; Access site left arm, observe access site for bleeding or S/SX (signs/symptoms) of infection every shift.; Check Bruit every shift, if applicable; Regular Renal Diet and [MEDICATION NAME]/[MEDICATION NAME] 2.5% Cream, apply 1 unit to [MEDICAL TREATMENT] site 1 hour prior on Tues, Thurs, Sat. R14's Dietary Progress Note, dated 11/21/19, documents, [MEDICAL TREATMENT]/Nutrition status: (R14's) weights will fluctuate related to fluid shifts with [MEDICAL TREATMENT]. Diet order: CCD (Carbohydrate controlled), Renal, limit milk to 1/2 cup daily with 2000 ML (milliliters) fluid restriction. R14's Progress Note, dated 11/23/19 at 3:00 PM documents, (R14) unable to go to [MEDICAL TREATMENT] due to lack of transportation. Spoke with (local bus service), they stated (R14) wasn't scheduled for transportation today. (R14) aware of issue. Spoke with ([MEDICAL TREATMENT] center), made aware of situation. R14's Progress Note, dated 11/23/19 at 3:30 PM documents, (R14) called this nurse to room, stating (R14) didn't feel well. Went on to say that (R14) felt fatigue and nausea. Requested to go to ER (emergency room) to get emergency [MEDICAL TREATMENT]. Per (R14's) request, transported via AMT to (local hospital). R14's Nursing Home to Hospital Transfer Form, dated 11/23/19, documents, Missed [MEDICAL TREATMENT] Thursday (11/21/19) and today (11/23/19). R14's Hospital Progress Note, dated 11/23/2020, documents, (R14) with a past medical history of [REDACTED]. (R14) was discharged about 4 days ago and since that time, (R14) reports that he has missed 2 [MEDICAL TREATMENT] sessions. He had been discharged to (nursing facility) and reports he was told he would not be able to get transportation to his [MEDICAL TREATMENT] session today. (R14) reports that while he was in his room today, he started having nausea without vomiting and also noted weakness. (R14) notes that due to missed [MEDICAL TREATMENT] (R14) decided to call (local ambulance) for presentation to the ED. admitted for uremic symptoms and volume overload. R14's (facility) 24 Hour I and O (Intake and Output) Report, dated 11/19/19 to 12/22/19, fail to accurately document physician ordered intake and output levels on 23 out of 28 days. R14's Treatment Administration Record, dated March 2020, documents that facility staff failed to document, Observation of access site for bleeding or signs/symptoms of infection every shift and Check bruit every shift for 9 out of 14 opportunities. On 3/9/2020 at 9:30 AM, R14 stated, My brother and I were homeless. I came to the facility in November because my Case Manager wanted me to be here so I had transportation to my [MEDICAL TREATMENT] appointments. Just before I

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F 0698 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) came here, I had missed a couple of [MEDICAL TREATMENT] appointments and I got very sick. My heart had stopped beating and I ended up in the ICU (Intensive Care Unit) for a few days. I go to [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday at 1:00. I missed two treatments after I first came here because for some reason the City bus didn't come and pick me up and the facility didn't take me to my appointments. Finally after I missed the second appointment, I was feeling so sick I told the nurse I was going to call the ambulance and go to the ER (emergency room). She didn't want to call for me, but she finally did. They did emergency [MEDICAL TREATMENT] on me for a couple of days and then sent me back here. On 3/10/20 at 1:30 PM, V16/Admissions stated, (R14) was admitted to our facility in November (2019). We knew prior to admission (R14) received [MEDICAL TREATMENT] three times a week. We do have a facility van which is available to transport residents to [MEDICAL TREATMENT] or doctor's appointments, with no charge. I don't know why (R14) was not provided transportation to [MEDICAL TREATMENT] (on 11/21/19 and 11/23/19). On 3/10/20 at 1:46 PM., V15/Advanced Practice Nurse (APN) for (local) [MEDICAL TREATMENT] Clinic stated, (R14) was admitted to the (facility) in November (19,2019) after (R14) had been hospitalized with heart failure secondary to being homeless and missing [MEDICAL TREATMENT] appointments due to transportation problems. The facility assured us they would be able to provide transportation or arrange transportation for (R14) so (R14) could receive (R14's) scheduled [MEDICAL TREATMENT] appointments. After (R14) missed two [MEDICAL TREATMENT] appointments (11/21/19 and 11/23/19), (R14) needed to be hospitalized again to receive emergency [MEDICAL TREATMENT] for two days. When a resident does not receive scheduled [MEDICAL TREATMENT], toxins build up in the body, which the body can not get rid of, which will lead to [MEDICAL CONDITION] and death. On 3/11/2020 at 9:30 AM, V1/Administrator stated, Our facility has a facility van that we use to transport residents to doctor's appointments. Last fall our van was broken and we didn't have a van driver. I don't know why (R14) wasn't provided transportation in November to (R14's) [MEDICAL TREATMENT] appointments. We could have called a non-emergency transport to take (R14). On 3/11/2020 at 11:00 AM, V2/Director of Nurses (DON) verified the facility did not transport R14 or assist in obtaining transportation for R14 for [MEDICAL TREATMENT] appointments in November. On 3/11/2020 at 11:05 AM, V14/Corporate Nurse verified facility staff did not complete physician ordered Intake and Outputs or physician-ordered [MEDICAL TREATMENT] site observations or bruit checks for R14, as ordered.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to attempt a gradual dose reduction (GDR) of an antipsychotic, and justify an increase in an antipsychotic medication for three of six residents (R40, R49, R58) reviewed for antipsychotics in the sample of 30. Findings include: The facility's Standards and Guidelines [MEDICAL CONDITION] Medications policy, dated 11/1/16, documents Standard: It will be the standard of the facility that [MEDICAL CONDITION] medication therapy shall be used only when it is necessary to treat a specific condition. This same policy also documents Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust or discontinue existing [MEDICAL CONDITION] medication (GDR (Gradual Dose Reduction)/Dose reduction as indicated). 1. On 3/8/20 at 7:50 AM, R40 was lying in bed in her room. R40 was cooperative with conversation and was not displaying any behaviors. R40's current physician order [REDACTED]. R40's Psychopharmacological Interdisciplinary Medication Review, dated 2/1[DATE]9, documents R40's [MEDICATION NAME] 1 milligram has a start date of 2/17/18. This form documents, Committee recommendations: Chart reviewed. Continues to have episodes of tearfulness and anger. No gradual dose reduction (GDR) recommended at this time. R40's behavior tracking sheets for October 2019- February 2020 documents R40 is being monitored for behaviors of withdrawn and self isolation. These tracking sheets document R40 is not having any behaviors. On 3/11/20 at 9:17 AM, V2 (Director of Nursing) confirmed that R40 has not had a GDR for her [MEDICATION NAME] in the last year. V2 stated, We can recommend it but if the doctor says no then the resident stays on it. 2. On [DATE] at 2:21 PM, V18 and V19 (Both Certified Nursing Assistants-CNAs) transferred R49 from R49's high back reclining wheel chair to R49's bed and provided incontinent care. R49 was pleasant and smiling not displaying any behaviors during any of her cares. R49's physician's orders [REDACTED]. R49's [MEDICAL CONDITION] Drug Review, dated 11/1[DATE]9, documents that R49 is receiving [MEDICATION NAME] 25 mg by mouth twice daily since it was initiated. The Review also documents that no GDR has been attempted because a reduction can be harmful to R49; however, no justification of how or why this could be harmful to R49. R49's MDS (Minimum Data Set), dated 1/15/20, documents in Section N Medications that R49 received seven days of an antipsychotic medication and no GDR has been attempted nor was there physician documentation of GDR being clinically contraindicated. R49's [MEDICAL CONDITION] Medication Use care plan, dated 1/24/20, documents that R49 is currently receiving an antipsychotic. The care plan also documents, Intervention: Consider reductions/discontinuance of medications when condition or behaviors for which drug was ordered are eliminated or reduced. R49's Behavior/Intervention Monthly Flow Records, dated 1/2020-3/2020, documents that R49 has not had any behavioral episodes during this three month period. R49's Consultant Pharmacist Recommendation to Physician, dated [DATE], documents, Federal guidelines state antipsychotic drugs should have an attempt at a GDR twice per year for the first year in two different quarters with at least one month between attempts, then annually thereafter. This resident (R49) has been taking [MEDICATION NAME] since 5/17/19. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? The recommendation has no documentation of a physician response to the Pharmacist's recommendation. On 0[DATE] at 11:05 AM, V14 (Corporate RN) stated that R49 has not had a GDR since her [MEDICATION NAME] was initially started. 3. R58's physician's orders [REDACTED]. R58's physician's orders [REDACTED]. R58's current physician's orders [REDACTED]. R58's MDS (Minimum Data Set), dated 2/20/20, documents in Section E Behaviors that R58 has not exhibited any behaviors, and in Section N Medications that R58 received seven days of an antipsychotic and no GDR has been attempted. R58's Behavior tracking, dated 1/2020-3/2020, documents that R58 has not had any behavioral episodes for this time period. On 3/09/20 at 8:16 AM, R58 was alert sitting up at dining room in high back reclining wheel chair being assisted by a staff member not exhibiting any behaviors. On [DATE] at 12:58 PM, V20 (Licensed Practical Nurse) provided gastrostomy tube cares for R58, and R58 remained calm and free of behaviors. R58's current medical record has no documentation of to warrant the increase in R58's [MEDICATION NAME]. On 3/11/20 at 11:03 AM, V7 (Care plan coordinator) stated, Prior to being admitted to the hospital, R58 was on six days a week of [MEDICATION NAME] 0.25 mg daily, however when he was readmitted the [MEDICATION NAME] was increased to [MEDICATION NAME] 0.25 mg daily for all seven days of the week. I'm not sure why his [MEDICATION NAME] was increased.
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview, and record review, the facility failed to ensure meals were at a warm temperature and safe. This failure has the potential to affect all 50 residents in the facility. Findings include: The facility's Dining Services Operations, test trays policy, dated 9/2017, documents the following: This is an audit tool to evaluate the accuracy of meal assembly and and the qualitative aspects of the meal. Data should be reviewed to identify any patterns of deficient practice that would trigger a quality improvement project. Frequency: Eight times per month, using alternating meals, days and diet plans. Testing includes the following criteria: Temperature of foods, portion sizes, appearance of food, quality and preparation, missing items or substitutions, therapeutic accuracy and tray completeness and cleanliness. Audits will be retained on file for a period of (blank) months. The facility was unable to provide test tray audits for the past year. On 3/09/20 at 12:36 PM, V6, Dietary Manager prepared a test tray. Temperatures of the food were immediately taken and were as follows: Beets-100 degrees, chicken-120 degrees, peaches 110 and rice 125. The food was bland and not palatable. On [DATE] at 12:33 PM, a cheeseburger was requested due to complaints about food, and specifically cheeseburgers. At this time, the cheese was lukewarm to touch, the hamburger patty was 120 degrees, the hamburger bun was cold and hard to touch. On [DATE]20, R14 and R43 stated the food is served cold or luke warm. On [DATE]20 at 1:30 PM, R1, R28, R31, R39, R50, and R61 attended the group meeting and had complaints of the food being cold all of the time. They all

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) stated that last week dinner was a toasted turkey and cheese sandwich that was served for dinner and the cheese was not even melted. All residents complained that the menu does not match what is being served, the food is cold or under cooked. The group agrees the cheeseburger is not cooked well and does not taste good. On 3/08/20 at 12:23 PM, R50 was alert and oriented sitting at the facility dining room table. R50 stated that the food is not very good, and by the time it reaches his table it is cold. R50 also stated that he has spoke to several people in the facility about these issues but it doesn't change anything. On 3/09/20 at 1:10 PM V6, Dietary Manager, stated she has had complaints of cold food and thinks it is because the food is served on cold plates.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to keep soiled linens in an acceptable receptacle during incontinence care for one of three resident (R19), reviewed for bowel and bladder continence, in a sample of 30. FINDINGS INCLUDE: The facility policy, Standard Precautions, dated 2017 documents, Standard precautions are based upon the principal that all blood, body fluids, secretions, non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions are intended to be applied to the care of all persons in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of standard precautions constitutes the primary strategy for preventing healthcare-associated transmission of infectious agents among residents and healthcare personnel. Appropriate infection control measures should be used in each resident interaction. R19's current (March 2020) Physician order [REDACTED]. R19's care plan, dated 12/23/19, includes the following Problems: (R19) is incontinent of bowel and bladder. (R19) is at risk for and has a history of related complications. This same document includes the following Interventions: Provide hygiene after voiding/BM (bowel movements)s to prevent skin breakdown; Change incontinence pad/brief. On 3/08/20 at 7:34 AM, (R19) was sitting in a wheel chair in the middle of the room. V10/Certified Nursing Assistant (CNA) was providing incontinence care for R19. A large pile of BM (bowel movement) soiled disposable incontinence briefs and disposable cleansing cloths were thrown on floor, in the vicinity of the trash can. Urine and BM soaked clothing, wash cloths and towels were lying on the floor. At that time, V10/CNA verified soiled linens and disposable briefs and cloths should be placed in a trash bag and not on the floor.