STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY LANE GARDENS REHAB & NURSING CTR	7820 PLEASANTVILLE ROAD PLEASANTVILLE, OH 43148

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 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #53's physician and family were promptly notified of decreased oral intake and avoidable weight loss sustained by the resident. This affected one resident (Resident #53) of four residents reviewed for nutrition. Findings include: Medical record review revealed Resident #53 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident's cognition was severely impaired, the resident required supervision with set up assistance with meals, had no significant weight changes, had a feeding tube and received less than 25% of nutritional needs through the feeding tube, received 501 milliliters or more of water flushes through the feeding tube and was on a mechanically altered diet. Review of the resident's weights and vital summary form revealed the resident weighed the following: on 03/23/17 at 184 pounds (#), on 04/06/17 at 185.4#, on 05/21/17 at 180.8# and on 06/19/17 at 172.2#. This revealed the resident lost 8.6# in one month from 05/21/17 to 06/19/17, a 4.8 percent (%) weight loss and lost 14.2# in three months which was a 7.6% weight loss. Review of the resident's nutrition/weight progress notes revealed on 04/07/17 the resident's weight was stable and Registered Dietitian #95 stated she would discontinue weekly weights. The plan at that time was to monitor every month and continue without tube feeding at that time. The resident's estimated nutritional needs were 1655 calories, 66 grams of protein and 2522 milliliters (ml.) of water per day. On 05/19/17, the progress note stated the resident was having decreased intakes, which could be related to the resident being on antibiotic (review of physician orders [REDACTED]. It was discussed with nursing increasing the water flushes through the resident's feeding tube and continue to monitor for the need of enteral feeding to be restarted if the resident's oral intake did not increase. On 05/2417 a quarterly review was completed and stated the resident's May 2017 weight was pending, intakes were zero to 75% with some meals being 50% and 100%. The diet order was for mechanical soft texture with a divided plate. The resident received a house shake at breakfast and the acceptance was varied. The resident was fed per staff. There were no new recommendations. A note dated, 05/31/17 revealed nursing called Registered Dietitian (RD) #95 on 05/30/17 in regards to the resident's decreased oral intake and wanted to decrease the water flushes back to 150 ml. twice daily. Intakes varied from 0% to 100% with many refusals noted too. The note stated to continue to follow weights to see if the restart of bolus enteral feedings were indicated. On 06/06/17, the resident's laboratory value which tested the visceral protein stores, [MEDICATION NAME] was noted to be low at 3.0 (normal 3.5 to 5.0) and it was noted a decline from the previous lab (3.3 level in month of 02/2017). The RD increased a protein supplement, Promod to 30 ml. twice daily to provide 20 grams of protein through the feeding tube and noted the bolus tube feedings may need to be restarted. There was not another nutrition/weight note until 06/19/17 which noted the resident's current body weight was 172.2# which reflected a 7.6% significant weight loss in 90 days and 13% significant weight loss in six months. RD #95 noted she would discuss with the interdisciplinary team about restarting bolus feeding through the resident's feeding tube. Intakes were zero to 50%. The resident had a house shake daily in place at breakfast and acceptance of this was good and would add another house shake at lunch as well. On 06/20/17, the resident was added to weekly weights due to weight loss to further evaluate. After surveyor intervention on 06/22/17, the physician was notified of the resident's significant weight loss and decreased oral intake and responded with regards to restarting the resident's tube feed and agreed with it. RD #95 recommended restarting a tube feed product, [MEDICATION NAME] 1.5 to run at 50 ml. continuously, until 500 ml. had infused from 8:00 P.M. to 6:00 A.M. This would provide 750 calories, 32 grams of protein and 380 ml. of free water. RD #95 noted that this would provide approximately 70% of the resident's estimated calorie and protein needs. Review of the residents meal intakes revealed the following: From 05/01/17 to 05/31/17 the resident had zero, 25% and 50% recorded meals for 60 times out of the 87 meals that were recorded and offered to the resident in that time period. This was equivalent to 69% of the residents meal intakes were 50% or less and 46% of the meals were 25% or less in the month of May 2017. The resident refused her nutritional house shake at breakfast 42% of the time in the month of 05/17. From 06/01/17 to 06/21/17 the resident had zero, 25% and 50% recorded meals for 41 times out of the 57 meals that were recorded and offered to the resident in that time period. This was equivalent to 72% of the residents meal intakes were 50% or less and 49% of the meals were 25% or less in the time period from 06/01/17 to 06/21/17. Interview with RD #95 on 06/22/17 at 9:46 A.M. revealed the resident always had a variable intake and the family wanted the resident off the tube feeding. The RD confirmed the physician and family were not notified of the resident's weight loss that occurred on 06/19/17 and were not notified of the resident's decline in meal intakes that were noted by nursing in 05/2017 per the nutrition/weight progress notes. The RD stated she was waiting for a monthly weight to be obtained to add any further calories to the resident's diet either by oral or feeding tube. The RD stated she thought the resident was still was on weekly weights and that nursing was not obtaining them. After surveyor intervention, the RD confirmed the RD recommended monthly weights in 04/2017. The RD was unaware of the facility's weight policy under new management company which occurred 01/2017 and stated she knew it was taking a long time to obtain a June weight. Interview with Unit Nurse Manager (UM) #51 on 06/22/17 at 9:59 A.M. confirmed the resident's physician and family were not notified of the resident's weight loss that occurred on 06/19/17. The UM stated the nurse was to document in the resident's electronic medical record if they notify the physician and/or family. Review of the facility's undated policy and procedure on change in a resident's condition or status revealed the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse supervisor/charge nurse will notify the resident's attending physician and resident's family or representative when there has been which included when there has been a significant change in the resident's physical/emotional/mental condition. Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status.
F 0159 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Properly hold, secure and manage each resident's personal money which is deposited with the nursing home.**

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

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F 0159 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Based on resident funds review and staff interview the facility failed to have a witness when Resident #5, Resident 10, Resident #11, Resident #27, Resident #40, Resident #42, and Resident #80 signed the authorization and agreement to handle resident funds. This affected seven residents (Resident #5, Resident 10, Resident #11, Resident #27, Resident #40, Resident #42, and Resident #80) out of 49 residents reviewed for resident funds. Census was 65. Findings include: On 06/22/17 a review of resident funds revealed there was not a witness signature when Resident #5, Resident 10, Resident #11, Resident #27, Resident #40, Resident #42, and Resident #80 signed the authorization and agreement to handle resident funds. On 06/22/17 at 10:38 A.M. an interview with Business Office Manager (BOM) #22 verified Resident #5, Resident 10, Resident #11, Resident #27, Resident #40, Resident #42, and Resident #80 did not have a witness when the authorization for resident funds was signed by the residents or legal representative. BOM #22 further stated she was not aware a witness was needed when the resident fund authorization as signed.
F 0221 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, manufacturer guideline review, policy review and staff interview, the facility failed to ensure Resident #44 was free from unnecessary restraints. This affected one resident (Resident #44) of three residents reviewed for restraints. The facility identified two residents who required the use of physical restraints. Findings include: Medical record review revealed Resident #44 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Fall Incident Report dated 02/17/17 revealed Resident #44 was sitting in a wheelchair in the lobby when he got out of the chair and sat down on the floor. The facility implemented a seat belt to the resident's wheelchair to prevent future falls. There was no evidence of a physician order, a pre-restraint assessment or consent prior to the use of the seat belt. Review of the care plan titled At Risk for Falls, revised 02/27/17 revealed the resident was to have an alarming seat belt when up in a wheelchair. There was no evidence of a restraint care plan or consent for the restraint. Review of the quarterly Restraint-Physical (RP) Evaluation dated 04/13/17 and the annual RP Evaluation dated 06/21/17 revealed Resident #44 had irreversible cognitive deficits associated with advanced dementia, declining mobility capabilities and minimal safety understanding. Resident #44's seat belt was assessed to be a restraint and considered to be effective. The reason was continued imminent danger to the resident or others due to unsteady gait, agitated behavior, aggressive behavior, forgets ambulation device, frequent falls, sliding out of chair/wheelchair, unbuckles seatbelt and attempts to self-transfer. The assessment indicated the resident was able to remove the seat belt; however, the alarm triggers staff to come to his side to reduce falls. Recommendations included to continue the use of the restraint. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #44 was severely impaired for daily decision-making, required extensive assist of two staff for transfers, had two or more falls since last assessment. Review of the medical record revealed no monitoring or physician order for [REDACTED]. Review of the Care Plan Progress Note dated 06/21/17 revealed the resident had significant deficits associated with dementia and a history of multiple falls from his wheelchair in the past year. By recommendation from the physician, a self releasing, alarming seat belt was obtained for the resident. Between 06/19/17 and 06/22/17, Resident #44 was observed to have a lap seat belt secured around his waist when he was in the wheelchair. Further observation revealed the following: On 06/19/17 at 10:58 A.M., the lap seat belt was loosely applied and observed drooping between the resident's legs. On 06/19/17 at 1:35 P.M., the lap seat belt was loosely applied allowing the straps to rest on the resident's knees. On 06/20/17 at 9:04 A.M., the lap seat belt was loosely applied and lying across the resident's upper thighs. On 06/19/17 at 2:19 P.M., interview with Registered Nurse (RN) #13 and State tested Nurse Aide #40 verified Resident #44's lap seat belt was loose and not applied properly. At the time of the interview, Resident #44 was unable to release the seatbelt; therefore, RN #13 correctly applied the lap seat belt for the resident. On 06/21/17 at 2:50 P.M., interview with the Director of Nursing (DON) verified there was no physician order, care plan or restraint reduction plan for Resident #44's alarming lap seat belt. On 06/22/17 at 10:13 A.M., interview with the DON verified the facility implemented an alarming lap seat belt in Resident #44's wheelchair after a fall on 02/17/17, and the lap seat belt was assessed as a restraint because the resident was not capable of consistently releasing the lap seat belt. On 06/22/17 at 3:05 P.M., interview with the Administrator stated Resident #44's cognition was severely impaired and the resident could release the lap seat belt at times, but not consistently. The Administrator stated the facility assessed the lap seat belt as a restraint because there were times the resident could not release the seat belt upon command. Review of the undated policy, Use of Restraints revealed restraints were only to be used for the safety and well-being of the residents and only after other alternatives have ben tried unsuccessfully. Prior to placing a resident in restraints, a pre-restraining assessment was to be completed and reviewed to determine the need for restraints. Restraints were only to be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The physician order was to include the specific reason for the restraint, how the restraint was to be used and the type of restraint and period of time for the use of the restraint. Restraint care plans were to reflect interventions that address not only the immediate medical symptoms but the underlying problem that may cause the symptoms. Review of the manufacturer guidelines: E-Z Release Belt Alarm revised 10/15/12 revealed the lap seat belt was to placed around the resident's waist and adjusted so that the belt was snug but not uncomfortably tight.
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to report to the State agency and investigate a resident's injury of unknown source. This affected one resident (Resident #74) of three residents reviewed for abuse. Findings include: Medical record review revealed Resident #74 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required extensive assistance with two persons assistance with bed mobility and transferring and had severe cognition impairment. Review the resident's progress notes revealed on 08/18/16 at 12:30 A.M. the resident was noted to have no injury noted from the 08/14/16 incident of an unwitnessed fall. On 08/19/16 at 8:35 P.M., a State tested nursing assistant (STNA) told Licensed Practical Nurse (LPN) #76 the resident's left wrist was bruised and swollen. The physician was contacted and the physician ordered for an x-ray. The results of the x-ray were a [MEDICAL CONDITION] radius that was probably acute. On 08/20/16 at 2:36 A.M. the physician ordered to wrap the resident's left wrist with an ace wrap and consult ortho on 08/22/16. Review of the medical record revealed there was no indication on how the resident sustained [REDACTED]. Review of the facility's Self-Reported incidents (SRI) revealed the facility did not report this injury of unknown source to the State agency. Interview with the Director of Nursing (DON) on 06/22/17 at 10:04 A.M. confirmed the facility did not complete an investigation of the resident's injury of unknown source and did not report this to the State agency. The DON stated they talked about it but never completed an investigation and felt the resident probably hit the railing while ambulating down the hallway. The DON confirmed there were no new interventions made after the resident's injury of unknown origin. Review of the facility's undated policy and procedure on investigating injury of unknown origin revealed an investigation of all unexplained injuries (which included injuries of unknown source) would be conducted by the Director of Nursing Services

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) or designee, to ensure the safety of all residents. The policy defined injury of unknown origin as an injury that met both the following conditions: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury was suspicious of the extent of the injury, or the location of the injury, or the number of injuries observed or the incidence of injuries over time. Review of the facility's undated policy and procedure on abuse reporting revealed that injuries of unknown origin would be investigated to rule out potential abuse. The State agency would be notified of the alleged or actual event of abuse and world be notified within 24-hours of the alleged incident.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to implement their abuse policy and procedures related to the reporting and investigating of an injury of unknown source involving Resident #74. This affected one resident (Resident #74) of three residents reviewed for abuse. Findings include: Medical record review revealed Resident #74 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required extensive assistance with two persons assistance with bed mobility and transferring and had severe cognition impairment. Review the resident's progress notes revealed on 08/18/16 at 12:30 A.M. the resident was noted to have no injury noted from the 08/14/16 incident of an unwitnessed fall. On 08/19/16 at 8:35 P.M., a State tested nursing assistant (STNA) told Licensed Practical Nurse (LPN) #76 the resident's left wrist was bruised and swollen. The physician was contacted and the physician ordered for an x-ray. The results of the x-ray were a [MEDICAL CONDITION] radius that was probably acute. On 08/20/16 at 2:36 A.M. the physician ordered to wrap the resident's left wrist with an ace wrap and consult ortho on 08/22/16. Review of the medical record revealed there was no indication on how the resident sustained [REDACTED]. Review of the facility's Self-Reported incidents (SRI) revealed the facility did not report this injury of unknown source to the state agency. Interview with the Director of Nursing (DON) on 06/22/17 at 10:04 A.M. confirmed the facility did not complete an investigation of the resident's injury of unknown source and did not report this to the State agency. The DON confirmed the facility did not follow their abuse policies and procedures. Review of the facility's undated policy and procedure on investigating injury of unknown origin revealed an investigation of all unexplained injuries (which included injuries of unknown source) would be conducted by the Director of Nursing Services or designee, to ensure the safety of all residents. The policy defined injury of unknown origin as an injury that met both the following conditions: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury was suspicious of: the extent of the injury, or the location of the injury, or the number of injuries observed or the incidence of injuries over time. Review of the facility's undated policy and procedure on abuse reporting revealed that injuries of unknown origin would be investigated to rule out potential abuse. The State agency would be notified of the alleged or actual event of abuse and world be notified within 24-hours of the alleged incident.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide a table at an appropriate height for Resident #18 to ensure adequate dining activities. This affected one resident (Resident #18) of 14 residents observed in the second floor dining room. Findings include: Medical record review revealed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #18 was severely impaired for daily decision-making, required limited assistance for locomotion on the unit and the resident was 60 inches tall. On 06/19/17 at 11:38 A.M., observation of the second floor dining room revealed Resident #18 was sitting in a short wheelchair that was pushed up to the table. The table top was at the height of the residents upper chest. Resident #18 was observed using a butter knife to try to reach her food and she was unable to reach her drinks that were placed to back of the cafeteria-style serving tray. On 06/20/2017 at 11:23 A.M., observation of the second floor dining room revealed Resident #18 was seated at a table that came up to the resident's chest. A lever handle was observed on the stand to adjust the height of the table. Other tables were observed in the dining room to be lower than the one Resident #18 was seated at. On 06/20/17 at 6:20 P.M., observation of the second floor dining room revealed Resident #18 was seated at a table that came up to the resident's chest. The resident was observed to reach up with utensils to reach her food. On 06/20/17 at 6:20 P.M., interview with Registered Nurse (RN) #58 verified Resident #18's wheelchair was shorter than others due to the resident's height. RN #58 verified the resident eats at the same table for all meals, the resident requires staff assistance to get to the dining room, the table height was chest high and the table was not an appropriate level for eating.
F 0252 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide a safe, clean, comfortable and homelike environment.** Based on observation and interview, the facility failed to ensure a homelike dining experience for residents on the second floor dementia unit. This affected 14 residents (Resident #11, #12, #15, #18, #20, #29, #42, #56, #59, #60, #63, #72, #74 and #76) of 25 residents who resided on the second floor dementia unit. Findings include: On 06/19/17 at 11:31 A.M., observation of the second floor dementia unit dining room revealed meals were delivered to Resident #11, #12, #15, #18, #20, #29, #42, #56, #59, #60, #63, #72, #74 and #76 on plastic, cafeteria-style serving trays. Staff were observed to uncover the food, did not remove the plates from the plate warmers and left all items on the serving tray. On 06/20/17 at 11:43 A.M., Resident #11, #12, #15, #18, #20, #29, #42, #56, #59, #60, #63, #72, #74 and #76 were observed in the second floor dining room. State tested nursing assistant (STNA) #28 and STNA #40 were observed delivering meal trays to the residents and all meals were left on the plastic, cafeteria-style serving trays. On 06/20/17 at 11:44 A.M., interview with STNA #28 verified meals on the dementia unit were left on the trays because sometimes a resident will grab at the others food. STNA #28 and #40 verified only residents on the dementia unit ate their meals on the plastic, cafeteria-style serving trays and it was not a homelike dining experience. On 06/20/17 at 6:20 P.M., interview with Registered Nurse #58 stated in the past resident food was removed from the plastic serving trays, but it changed around the first of the year. States she did not know the reason for the change. On 06/21/17 at 10:51 A.M., interview with the Director of Nursing (DON) verified only residents residing on the second floor dementia unit had their food left on the plastic, serving trays during meals. The DON stated it served as a barrier for the residents and verified residents on the dementia unit had not been assessed for the need for a barrier during meals. The DON stated it was a facility procedure and verified it was not homelike.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide housekeeping and maintenance services.** Based on observation, record review and interview the facility failed to ensure Resident #44's wheelchair and lap belt were clean. This affected one resident (Resident #44) of 36 residents observed for clean equipment. Findings include: On 06/19/17 at 11:14 A.M. an observation was made of Resident #44 sitting in a wheelchair. Resident #44's seatbelt and

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) wheelchair seat had dried stains and food debris. On 06/21/17 at 10:57 A.M. Resident #44 was out of the facility but an observation was made of his wheelchair. The seatbelt to Resident #44's wheelchair had dark stains, the metal bars from the seat to the wheels had dried food on them, and the seat cushion also had dried food. On 06/21/17 at 11:01 A.M. State tested Nursing Assistant (STNA) #47 verified there was dried food and stains on Resident #44's wheelchair. STNA #47 stated nightshift was responsible to clean the wheelchairs. Review of the wheelchair cleaning schedule revealed Resident #44's wheelchair was to be cleaned on 06/20/17.
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure comprehensive periodic Minimum Data Set (MDS) 3.0 assessments were accurate related to functional status and restraint use for Resident #44 and Resident #72. This affected two residents (Resident #44 and #72) of 16 residents reviewed for assessments. Findings include: 1. Medical record review revealed Resident #44 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #44 was severely impaired for daily decision-making, required extensive assist of two staff for transfers, had two or more falls since last assessment with no injury and did not use a restraint. Review of the Fall Incident Report dated 02/17/17 revealed Resident #44 was sitting in a wheelchair in the lobby when he got out of the chair and sat down on the floor. The facility implemented a seat belt to the resident's wheelchair to prevent future falls. Review of the quarterly Restraint-Physical (RP) Evaluation dated 04/13/17 revealed Resident #44 had irreversible cognitive deficits associated with advanced dementia, declining mobility capabilities and minimal safety understanding. Resident #44 utilized a seat belt that was assessed to be a restraint and considered to be effective. Recommendations included to continue the use of the restraint. On 06/22/17 at 10:13 A.M., interview with the Director of Nursing (DON) verified Resident #44 was not capable of releasing the lap seat belt consistently, the lap seat belt was assessed as a restraint and the quarterly MDS assessment dated [DATE] did not reflect the use of a restraint. 2. Medical record review revealed Resident #72 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #72 required limited assistance with dressing. Review of the annual MDS assessment dated [DATE] revealed the resident required supervision with dressing. Review of the Progress Notes and ADL (activities of daily living) Documentation Survey Report dated 12/23/16 through 12/29/16 revealed no documentation of the resident's ability to dress herself. Review of the medical record revealed no specific information regarding the amount of assistance Resident #72 required for dressing between 12/23/16 and 12/29/16. On 06/21/17 at 10:51 A.M., interview with the Director of Nursing (DON) stated the facility did not document the amount of assistance Resident #72 required with dressing and verified there was no evidence the self-performance assessment on the quarterly MDS assessment dated [DATE] was accurate. The MDS nurse was unavailable for interview between 06/19/17 and 06/22/17.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #2 had a plan of care in place for the specialized services she was receiving. This affected one resident (Resident #2) of one resident reviewed for Preadmission Screening and Resident Review (PASRR) level two services. The facility identified only one resident receiving PASRR level two services. Findings include: Medical record review revealed Resident #2 was admitted to the facility in 05/15/96 with medical [DIAGNOSES REDACTED]. Record review revealed the resident left the facility and attended a day program five days per week. Review of the resident's current plan of care revealed no evidence a care plan had been developed related to the resident's specialized service and day program. Interview with Licensed Social Worker #77 on 06/21/17 at 1:40 P.M. confirmed the resident did not have a care plan in place related to the specialized services being provided or attending a day program five times per week.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to revise care plans to reflect Resident #72's needed assistance with dressing. This affected one resident (Resident #72) of three residents reviewed for activities of daily living (ADL). Findings include: Medical record review revealed Resident #72 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #72 required supervision with dressing. Review of the General Progress Note dated 03/30/17 revealed Resident #72 would dress herself with supervision. Review of the care plan titled ADL Self-care deficit related to physical limitations, revised 01/13/16 revealed Resident #72 required limited to extensive assist at times and required one person assistance with dressing. On 06/22/17 at 9:02 A.M., interview with Unit Manager #51 verified Resident #72 required supervision and cues with dressing, and the care plan had not been revised to reflect this.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure skin conditions were monitored as ordered for Resident #54. This affected one resident (Resident #54) of two residents reviewed for pressure ulcers. Findings include: Medical record review revealed Resident #54 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan titled Resistive/Noncompliant with Care,revised 04/19/17 revealed the resident was noncompliant with treatments and incontinence care at times. Interventions included to notify the physician of noncompliance as needed and to educate the resident on the risks including skin alterations. Review of the quarterly Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] revealed Resident #54 was at moderate risk for skin breakdown. Review of Resident #54's monthly Physician order [REDACTED]. On 03/07/17, an order was written to cleanse the resident's left upper thigh with wound cleanser, pat dry and apply a dressing every three days and as needed. The treatment was discontinued on 03/08/17 and there was no evidence a new treatment was ordered or implemented until 04/29/17. Review of the Treatment Sheets dated March 2017 and April 2017 revealed no evidence a treatment was completed to Resident #54's left upper thigh between 03/08/17 and 04/29/17. Review of the Treatment Sheets dated March 2017 through May 2017 revealed weekly skin assessments were not completed as

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) ordered on [DATE], 03/21/17, 03/28/17, 04/18/17, 04/25/17, 05/03/17, 05/17/17 or 05/31/17. Review of the Skin Alteration Record -Do Not Use for Pressure Ulcers assessment dated [DATE] revealed a denuded area with dark pink/red tissue and a scant amount of thin red serosanguineous drainage to the left upper thigh. The area was assessed to have no depth; however, serosanguineous drainage was documented on 03/07/17, 03/09/17 and 03/14/17. Review of the Skin Condition Record revealed the left hip area was to be reassessed weekly. Review of the record revealed no evidence a skin assessment was completed between 03/14/17 and 04/04/17, between 04/04/17 and 04/29/17, or between 04/29/17 and 05/09/17. On 06/19/17 at 10:45 A.M., the resident refused to allow staff or the surveyor observe the skin impairment. On 06/20/17 at 10:53 A.M., interview with Registered Nurse (RN) #21 stated all measurements were documented in the progress notes or on the non-pressure skin sheets. RN #21 verified no evidence of weekly skin impairment assessments and stated the resident often refuses care and treatment to the area. On 06/22/17 at 9:57 A.M., interview with Unit Manager (RN) #51 verified Resident #54's non-pressure skin impairment should have been assessed weekly. RN #51 stated she could not comment on the accuracy of the assessments completed on 03/07/1, 03/09/17 and 03/14/17; however, drainage normally comes from an open wound. RN #51 verified there was no evidence in the record of a weekly assessment completed between 03/14/17 and 04/04/17, between 04/04/17 and 04/29/17, or between 04/29/17 and 05/09/17 for Resident #54.
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure fall safety interventions were in place as planned for Resident #37 and Resident #74, failed to ensure a safety belt restraining device was properly and safely applied to Resident #44 and failed to ensure chemical hazards were securely and safely stored to prevent access to Resident #30, #44 and #63 who were assessed to exhibit cognitive impairment. Actual harm occurred when Resident #37, who was at risk for falls sustained a fall requiring hospitalization . The fall resulted in the resident requiring sutures to the head, a possible hip fracture and acute intracranial injury. There was no evidence fall/safety interventions were in place at the time of the fall to prevent the fall from occurring. This affected two residents (Resident #37 and #74) of three residents reviewed for accidents, one resident (Resident #44) of two residents reviewed for physical restraints and three residents (Resident #30, #44 and #63) of 35 residents whose rooms were observed. Findings include: 1. Closed medical record review revealed Resident #37 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident's cognition was severely impaired. The assessment revealed the resident required extensive assistance with two-person physical assistance for bed mobility and transferring. Record review revealed the resident was admitted to Hospice services on 05/19/17. Review of the resident's fall plan of care, dated 05/10/17 revealed the resident was at a high risk for falls related to gait/balance problems, incontinence and an unawareness of safety needs. The care plan also reflected the resident had fallen prior to admission while living in the community. The goal was for the resident to be free of falls. The resident had three fall interventions, to anticipate and meet the resident's needs, ensure the resident was wearing appropriate footwear when ambulating, transferring or mobilizing in wheelchair and for physical therapy to evaluate and treat as ordered or as needed. Review of Resident #37's progress notes revealed on 05/19/17 at 8:25 P.M. the resident was sitting in his wheelchair in front of the nurse's station, waiting to get a shower. A nurse was passing medication on another unit and heard a loud thump and saw the resident laying on the floor and screaming for help. The resident had a new skin tear on top of his head and on his left and right elbow. A visitor who witnessed the fall called 911. The emergency medical team arrived at the facility and spoke with the resident's power of attorney and requested the resident be sent to the hospital to be examined. A resident, who had witnessed the resident fall revealed he tried to stand up and fell hitting his head and shoulder on the wheelchair then on the ground. Review of the emergency room (ER) visit, dated 05/19/17 revealed Resident #37's level of consciousness had decreased since the fall. The ER physician noted the resident had a possible hip fracture and possible acute intracranial injury. The documented clinical impression included: Fall, Head Injury and Left Hip Injury. The resident received sutures to his head. Family and Hospice staff discussion with the ER physician revealed no additional imaging studies/testing at that time and family requested the resident be transferred to an inpatient Hospice facility. Review of the facility's fall investigation revealed no evidence of the planned fall interventions being in place prior to or at the time of the fall. The fall investigation included documentation of the resident's injuries, a sentence from the nurse that assisted the resident and a resident witness statement from the resident who witnessed the resident fall. The investigation also noted the resident was confused, ambulatory without assistance and an active exit seeker. Interview with the Director of Nursing (DON) on 6/20/17 at 3:05 P.M. verified Resident #37 sustained a fall with injury on 05/19/17. The DON also verified the facility fall investigation did not including any evidence that fall/safety interventions were in place prior to or at the time of the fall. 2. Medical record review revealed the Resident #74 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required extensive assistance with two persons assistance with bed mobility and transferring. The assessment also noted the resident had severe cognitive impairment and no falls since the last assessment. Review of the resident's fall plan of care dated 06/30/16 revealed the resident was at risk for falls due to dementia. The goal was to minimize for falls. Interventions included for the resident to have an anti-roll back to wheelchair, assist as needed for toileting at routine times such as upon arising in the morning, before and after meals, activities and bed time, bed in low position, body pillow when in bed, have commonly used articles within reach and Dycem to wheelchair under cushion. Review of the resident's progress note, dated 01/09/17 at 12:15 A.M., revealed the nurse was notified by a State tested nursing assistant (STNA) the resident was on floor. Resident #74 was sitting on the floor next to her bed, with her back resting against the bed and both legs stretched out in front of her. No injuries were noted. Review of the facility's fall investigation revealed there was no indication the resident's bed was in low position and/or if the resident was toileted prior to her being assisted to bed. Review of the the resident's progress notes dated 06/14/17 at 6:31 A.M. revealed an STNA called the nurse into the resident's room and noted the resident was on the floor at the side of bed. Her legs were outstretched behind her with her arms bent at the elbows at her side. The resident was noted to be assisted to the side of her low bed with a gait belt. Skin assessment revealed a small purplish area developing on the right front shoulder blade. Review of the facility's fall investigation revealed there was no indication a perimeter mattress was in place, if the resident toileted prior to her being assisted to bed, if the resident's call light was within reach and/or if it was on. Interview with the Director of Nursing on 06/22/17 at 10:04 A.M. confirmed the resident's fall investigations did not include if fall interventions were in place prior to and at the time of the above falls. Review of the facility's undated policy and procedure on falls and falls managing revealed the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 3. Medical record review revealed Resident #44 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan titled At Risk for Falls, revised 02/27/17 revealed the resident had an alarming seat belt that was to be assessed when the resident was in his wheelchair. Review of the quarterly Restraint-Physical (RP) Evaluation dated 04/13/17 and the annual RP Evaluation dated 06/21/17 revealed Resident #44 had irreversible cognitive deficits associated with advanced dementia, declining mobility capabilities and minimal safety understanding. Resident #44 had an alarming seat belt that was assessed to be a restraint.

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) Between 06/19/17 and 06/22/17, Resident #44 was observed to have a lap seat belt secured around his waist when he was in the wheelchair. Further observation revealed the following: On 06/19/17 at 10:58 A.M., the lap seat belt was loosely applied and observed drooping between the resident's legs. On 06/19/17 at 1:35 P.M., the lap seat belt was loosely applied allowing the straps to rest on the resident's knees. On 06/19/17 at 2:19 P.M., interview with Registered Nurse (RN) #13 and STNA #40 verified Resident #44's lap seat belt was loose and not applied properly. At the time of the interview, Resident #44 was unable to release the seatbelt; therefore, RN #13 correctly applied the lap seat belt for the resident. On 06/20/17 at 9:04 A.M., the lap seat belt was observed loosely applied and lying across the resident's upper thighs. Registered Nurse #58 verified the lap seat belt was not snug. Review of the manufacturer guidelines: E-Z Release Belt Alarm revised 10/15/12 revealed the belt was to placed around the resident's waist and adjusted so that the belt was snug. 4. Record review revealed Resident #44 was admitted on [DATE] with a [DIAGNOSES REDACTED].#44 had severe cognitive impairment. Record review revealed Resident #30 was admitted on [DATE] with a [DIAGNOSES REDACTED].#30 had severe cognitive impairment. Record review revealed Resident #63 was admitted on [DATE] with a [DIAGNOSES REDACTED].#63 had severe cognitive impairment. On 06/19/17 during an initial facility tour revealed skin repair cream dispensers were observed on the wall above Resident #44, Resident #30, and Resident #63's bed. The beds were observed against the wall and the dispensers were located directly above the bed approximately where the resident's thigh would be when the resident was lying in bed making the dispensers easily accessible to residents when they were lying or sitting up in bed. Medline Remedy skin repair cream was noted in all three dispensers. On 06/22/17 at 11:01 A.M. an interview with Administrator #37 revealed the skin repair cream dispensers had been in place since he was the administrator. On 06/22/17 at 11:03 A.M. an interview with Director of Nursing (DON) #79 revealed the previous company had skin repair cream dispensers put in the rooms but the lotion dispensers were not filled especially in the rooms of residents with dementia. On 06/22/17 at 11:17 A.M. STNA #65 verified the skin repair cream dispensers had cream in them. STNA #65 stated the refills were kept in central supply and were filled by maintenance or nursing staff. STNA #65 stated the skin repair cream was mainly used by the staff for dry hands and was not used on the residents. On 06/22/17 an interview with DON #79 revealed the label only indicated the product was for external use and there was no Material Safety Data Sheet (MSDS) available and most of the ingredients appeared to be natural. Review of the label on the skin repair cream revealed it was for external use only and to avoid getting the cream in a persons eyes. The MSDS sheet on www.medexsupply.com revealed if there was contact with the skin repair cream and the eyes, the persons eyes should be flushed with water and medical attention should be taken if eyes continued to be irritated. The MSDS also revealed medical attention was needed if large quantities were ingested.
F 0325 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #53's nutritional needs were met to avoid severe weight loss. Actual harm occurred when Resident #53, who received nutrition and hydration both orally and via a gastrostomy tube exhibited decreased oral intake which resulted in a 4.8 percent weight loss in one month and a severe weight loss of 7.6% in three months with no timely and effective nutritional interventions being initiated. This affected one resident (Resident #53) of four residents reviewed for nutrition. The facility failed to identify any residents who had sustained an unplanned significant weight loss/gain. Findings include: Medical record review revealed Resident #53 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident's cognition was severely impaired, the resident required supervision with set up assistance with meals, had no significant weight changes, had a feeding tube and received less than 25% of nutritional needs through the feeding tube, received 501 milliliters or more of water flushes through the feeding tube and was on a mechanically altered diet. Review of the resident's nutrition plan of care, dated 09/26/12 and last revised on 06/19/17 revealed the resident was at nutrition risk due to presence of chewing and swallowing difficulty, history of significant weight loss, meals intakes less than 50% at most meals and refuses often, impaired cognition which may alter intake and appetite and low [MEDICATION NAME]. Review of Resident #53's weights and vital summary form revealed the following resident weights: On 03/23/17 at 184 pounds (#), on 04/06/17 at 185.4#, on 05/21/17 at 180.8# and on 06/19/17 at 172.2#. This revealed the resident lost 8.6# in one month from 05/21/17 to 06/19/17 which reflected a 4.8 percent (%) weight loss and lost 14.2# in three months which indicated a severe weight loss in three months of 7.6%. Review of the resident's nutrition/weight progress notes revealed on 04/07/17 the resident's weight was documented as being stable and Registered Dietitian #95 stated she would discontinue weekly weights. The plan at that time was to monitor every month and continue without tube feeding at that time. The resident's estimated nutritional needs were 1655 calories, 66 grams of protein and 2522 milliliters (ml.) of water per day. On 05/19/17 a nutrition/weight progress note revealed the resident was having decreased intakes, which could be related to the resident being on antibiotic (review of physician orders [REDACTED]. It was discussed with nursing and the plan was to increase the water flushes through the resident's feeding tube and continue to monitor for the need of enteral feeding to be restarted if the resident's oral intake did not increase. On 05/24/17 a quarterly review was completed which noted the resident's May 2017 weight was pending, intakes were zero to 75% with some meals being 50% and 100%. The diet order was for mechanical soft texture with a divided plate. The resident received a house shake at breakfast and the acceptance was varied. The resident was fed per staff. There were no new recommendations at that time. A note dated 05/31/17 revealed nursing called Registered Dietitian (RD) #95 on 05/30/17 in regards to the resident's decreased oral intake and wanted to decrease the water flushes back to 150 ml. twice daily. Intakes varied from 0% to 100% with many refusals noted too. The note stated to continue to follow weights to see if the restart of bolus enteral feedings were indicated. Review of the resident's care conference form dated 06/02/17 revealed the resident's June 2017 weight was pending, the resident was eating poorly, had gradual weight loss, was at risk for significant weight loss and had a decline in visceral protein stores. The form revealed a Promod supplement was increased and the resident had poor intakes and refusals. RD #95 stated the goal body weight was to be no lower than 180#. On 06/06/17, the resident's laboratory value which tested the visceral protein stores, [MEDICATION NAME] was low at 3.0 (normal 3.5 to 5.0) and it was noted a decline from the previous lab (3.3 level in month of 02/2017). The RD increased a protein supplement, Promod to 30 ml. twice daily to provide 20 grams of protein through the feeding tube and noted the bolus tube feedings may need to be restarted. There was not another nutrition/weight note until 06/19/17 which stated the resident's current body weight was 172.2# which was a 7.6% significant weight loss in 90 days and 13% significant weight loss in six months. RD #95 noted she would discuss with the interdisciplinary team about restarting bolus feeding through the resident's gastrostomy tube. Intakes were zero to 50%. The resident had a house shake daily in place at breakfast and acceptance of this was good and the RD would add another house shake at lunch as well. On 06/20/17, the resident was added to weekly weights due to weight loss to further evaluate. After surveyor intervention on 06/22/17, the physician was notified of the resident's weight loss and decreased oral intake and responded with regards to restarting the resident's tube feed and agreed with the RD's recommendation. RD #95 recommended restarting a tube feed product, [MEDICATION NAME] 1.5 to run at 50 ml. continuously, until 500 ml. had infused from 8:00 P.M. to 6:00 A.M. This would provide 750 calories, 32 grams of protein and 380 ml. of free water. RD #95 noted that this would provide approximately 70% of the resident's estimated calorie and protein needs.

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F 0325 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) Review of the residents meal intakes revealed the following: From 05/01/17 to 05/31/17 the resident had zero, 25% and 50% recorded meals for 60 times out of the 87 meals that were recorded and offered to the resident in that time period. This was equivalent to 69% of the residents meal intakes were 50% or less and 46% of the meals were 25% or less in the month of May 2017. The resident refused her nutritional house shake at breakfast 42% of the time in the month of 05/2017. From 06/01/17 to 06/21/17 the resident had zero, 25% and 50% recorded meals for 41 times out of the 57 meals that were recorded and offered to the resident in that time period. This was equivalent to 72% of the residents meal intakes were 50% or less and 49% of the meals were 25% or less in the time period from 06/01/17 to 06/21/17. Observation of Resident #53 on 06/20/17 at 11:54 A.M. revealed she was sitting in the resident lounge area and a State tested nursing assistant (STNA) brought the resident's meal tray and placed it on a bedside table. The resident received spaghetti, mixed vegetables, a dinner roll on a divided plated and also received a bowl of cheesecake, a nutritional health shake and a carton of 2% milk. Observation of STNA #47 on 06/20/17 at 12:28 P.M. revealed she asked the resident if she was full and the resident responded yes and then the STNA removed the tray from the resident. Interview with STNA #47 on 12:28 P.M. revealed she felt the resident ate 25% of her meal and 100% of her nutritional health shake. The STNA confirmed she did not offer the resident any substitutes. Interview with RD #95 on 06/22/17 at 9:46 A.M. revealed the resident always had a variable intake and the family wanted the resident off the tube feeding. The RD confirmed the physician and family were not notified of the resident's weight loss that occurred on 06/19/17 and were not notified of the residents decline in meal intakes that were noted by nursing in 05/2017 per the nutrition/weight progress notes. The RD stated she was waiting for a monthly weight to be obtained to add any further calories to the resident's diet either by oral or feeding tube. The RD stated she thought the resident was on weekly weights and that nursing was not obtaining them. After surveyor intervention, the RD confirmed the RD recommended monthly weights in 04/2017. The RD was unaware of the facility's weight policy under new management company which occurred 01/2017 and stated she knew it was taking a long time to obtain a June weight. Interview with Unit Nurse Manager (UM) #51 on 06/22/17 at 9:59 A.M. revealed monthly weights were to be done the first week. The UM was unable to answer why Resident #53 was not weighed the first week in June and stated monthly weights were generated in the facility's electronic medical record so nursing knew who to weigh. The UM stated RD #95 told nursing what weights in general were missing for residents, including Resident #53. The UM stated the facility does not have weight meeting but the RD would notify nursing of significant weight changes. Review of the facility's undated policy and procedure on enteral nutrition revealed adequate nutritional support through enteral feeding would be provided to residents as ordered. The decision to continue or discontinue the use of the feeding tube would be made through collaboration between the interdisciplinary team, the physician and the resident. Residents receiving enteral nutrition would be periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments would be documented and any changes would be made to the care plan. Input from the resident or legal representative will be included in the assessment.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Medical record review revealed Resident #72 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the preliminary urine culture results, dated 05/31/17 revealed the resident's urine was cloudy and positive for [MEDICATION NAME] and 3+ leukocytes. The resident was ordered to receive [MEDICATION NAME], an antibiotic 250 milligrams (mg) three times a day for 10 days and then obtain another urine specimen from a straight catherization to recheck for an infection. Review of the general progress note, dated 06/01/17 revealed urine obtained to send for urinalysis and culture due to dark amber colored urine with an odor. Encouraged resident to try to drink more fluids. Review of the Medication Administration Record [REDACTED]. Review of the final urine culture results dated 06/03/17 revealed the resident had a urinary tract infection. The resident's urine had greater than 100,000 CFU/mL Escherichia coli (E. Coli) a gram negative bacteria that was resistant to [MEDICATION NAME]. The physician ordered to discontinue [MEDICATION NAME] on 06/03/17 and start [MEDICATION NAME] (antibiotic) 100 mg twice a day for seven days to treat the resident's urinary tract infection. On 06/21/17 at 8:11 A.M., interview with the Director of Nursing (DON) verified Resident #72 received three unnecessary doses of [MEDICATION NAME] for an urinary tract infection [MEDICAL CONDITION] before the final culture result was received. The DON verified the resident's UTI bacteria was resistive to [MEDICATION NAME] and the resident had to be started on a different antibiotic to treat the infection. Based on record review and staff interview the facility failed to complete behavior monitoring related to Resident #42's as needed anti-anxiety medication, [MEDICATION NAME] and failed to prevent Resident #72 from receiving unnecessary doses of an antibiotic, [MEDICATION NAME]. This affected two residents (Resident #42 and #72) of five residents reviewed for unnecessary medications. Findings Include: 1. Review of Resident #42's medical record revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#42's medical record revealed there was no behavior charting documented for the as needed [MEDICATION NAME] given since the resident started the medication on 04/24/17. Review of Resident #42's Medication Administration Record [REDACTED]. Interview on 06/21/17 at 1:30 P.M. with the Director of Nursing (DON) revealed if a resident exhibited a behavior the nurse would document the incident and take it to the next's days morning meeting and the team would determine if the behavior should be added to an alert charting. The DON stated if the behavior was added to the alert charting then nurses would chart on the resident twice a day for the allotted time. The DON stated there was an internal document used to let the nurses know which resident needed charted on, for behaviors but the internal document was not kept. The DON verified there was no behavior monitoring documentation completed for Resident #42 for the as needed [MEDICATION NAME] 0.5 mg used for anxiety.
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure hypertensive medication and anticoagulants were administered as ordered. This affected one resident (Resident #72) of five residents reviewed for unnecessary medication use. Findings include: Medical record review revealed Resident #72 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set 3.0 assessment dated [DATE] revealed the resident was severely impaired for daily decision-making and received anticoagulants daily. Review of Resident #72's monthly physician orders [REDACTED]. The medication was to be held if the resident's heart rate (HR) was below 60 beats per minute. The resident was also ordered to receive [MEDICATION NAME] (anticoagulant) six days a week with various dosages depending on anticoagulation levels. Review of the Medication Administration Record [REDACTED]. Review of the MAR indicated [REDACTED]. Review of the care plan titled, Anticoagulant Therapy dated 09/29/15 revealed interventions including to administer medications per physician orders. Review of the care plan titled [MEDICAL CONDITION] related to arrhythmia, hypertension and [MEDICAL CONDITION] dated 03/30/15 revealed interventions including to administer medication per physician orders. On 06/21/17 at 2:50 P.M., interview with the Director of Nursing verified Resident #72's [MEDICATION NAME] and [MEDICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. BUILDING _____ B. WING _____	06/22/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY LANE GARDENS REHAB & NURSING CTR	7820 PLEASANTVILLE ROAD PLEASANTVILLE, OH 43148

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 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) NAME] medications were not administered as ordered on the above dates.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observation, record review and interview the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect 64 of 64 residents identified by the facility to receive meal trays from the kitchen. Findings include: On 06/21/17 at 10:55 A.M. kitchen observations with Dietary Manager #67 revealed there were five light fixtures attached to the hood in the kitchen. The light fixtures were above a stove cooking top along with an oven and steamer. The light fixtures had a thick layer of grease and large dust-like particles covering a large portion of the light fixtures. The general duty safety switch box/unit was located below the hood and behind the oven and it also had a thick layer of grease with dust-like particles over the switch box/unit. These findings were confirmed via interview with Dietary Manager #67 at the time of the observation. Review of the facility's undated policy and procedure on hood cleaning revealed the facility considered food preparation and sanitation important and would work to ensure a clean working environment in the kitchen.
F 0406 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give or get specialized rehabilitative services per the patient's assessment or plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #2 had an integrated plan of care developed between the facility and the day program to facilitate the resident's highest practicable functioning level. This affected one resident (Resident #2) of one resident reviewed for Preadmission Screening and Resident Review (PASRR) level two services. The facility identified only one resident receiving PASRR level two services. Findings include: Medical record review revealed Resident #2 was admitted to the facility in 05/15/96 with medical [DIAGNOSES REDACTED]. Record review revealed the resident attended a day program at an offsite location five days per week. Review of the resident's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident's cognition was intact. Interview with Resident #2 on 06/22/17 at 7:45 A.M. revealed she left the facility five days per week to go to work. During the interview the resident stated she would like a job so she could earn money and then stated doesn't everyone. She stated while at the day program she shreds papers into recycling, works on taking phone calls and writing down the messages. Interview with Licensed Social Worker (LSW) #77 on 06/21/17 at 1:40 P.M. revealed an annual PASRR was not in the resident's medical record and the resident's individual health plan (IHP) from the State health program for specialized services was not in the resident's medical record. The LSW verified the resident goes out to a day program five times per week. The LSW indicated she has never seen an IHP before until after surveyor intervention on 06/21/17 when she had the day program fax it over for review . The LSW stated she was unsure if the resident was compensated for the work done at the day program. Interview with Day Program Provider #96 on 06/21/17 at 2:14 P.M. revealed the resident had expressed she does want a job and needed assistance in finding one. The day program assisted the resident with job skills so if she would want to apply for the job, it would be up to the facility to assist the resident in finding a job.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation and staff interview the facility failed to ensure all medications were properly labeled and stored. This affected two residents (Resident #3 and #4) and had the potential to affect all residents residing on the B-hall. The facility census was 65. Findings Include: Observation on 06/21/17 at 10:04 A.M. of the medication storage on the B-hall revealed a medication cart contained one Levemir flex pen that was not not dated when opened for Resident #4 and one Victoza flex pen that was not dated when opened for Resident #3 (both flex pen contained insulin medications). There was one medication cup with two brown oval pills observed in it that was not labeled and one medication cup in the narcotic drawer that had one small white pill that was not labeled. Interview on 06/21/17 at 10:04 A.M. with the unit licensed practical nurse verified the two insulin flex pens were not dated when opened and also verified the presence of two medication cups in the cart with pills in them that were not labeled. The LPN indicated all insulin was to be dated when opened and that all medications are to be in original containers and properly labeled.
F 0464 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide a table at an appropriate height for Resident #18 for dining activities. This affected one resident (Resident #18) of 14 residents observed in the second floor dining room. Findings include: Medical record review revealed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #18 was severely impaired for daily decision-making, required limited assistance for locomotion on the unit and the resident was 60 inches tall. On 06/19/17 at 11:38 A.M., observation of the second floor dining room revealed Resident #18 was sitting in a short wheelchair that was pushed up to the table. The table top was at the height of the residents upper chest. Resident #18 was observed using a butter knife to try to reach her food and she was unable to reach her drinks that were placed to back of the cafeteria-style serving tray. On 06/20/2017 at 11:23 A.M., observation of the second floor dining room revealed Resident #18 was seated at a table that came up to the resident's chest. A lever handle was observed on the stand to adjust the height of the table. Other tables were observed in the dining room to be lower than the one Resident #18 was seated at. On 06/20/17 at 6:20 P.M., observation of the second floor dining room revealed Resident #18 was seated at a table that came up to the resident's chest. The resident was observed to reach up with utensils to reach her food. On 06/20/17 at 6:20 P.M., interview with Registered Nurse (RN) #58 verified Resident #18's wheelchair was shorter than others due to the resident's height. RN #58 verified the resident eats at the same table for all meals, the resident requires staff assistance to get to the dining room, the table height was chest high and the table was not an appropriate level for eating.