STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145696	A. BUILDING _____ B. WING _____	10/14/2011

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NILES NSG & REHAB CTR	9777 GREENWOOD NILES, IL 60714

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F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint Investigation #1192529- IL 54151-F-281;F-309	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		11/11/11

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

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F 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These	F 156		

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requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
A. Based on observation and interview the facility failed to post information on Medicare and Medicaid services in a location accessible to residents. This affects all 265 residents in the facility.

Findings include:

On 10/11/11 the survey team entered the facility and there was no posting of Medicare and Medication information visible. During the environmental tour on 10/12/11 at approximately 11am, again there was no posting visible. On 10/13/11 at approximately 9:30am, E1

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(Administrator) was asked to locate the facility's posting on Medicare and Medicaid services. Surveyor accompanied E1 as he looked for the posting in several locations on the first of five floors and the posting was not be found. E1 stated that there is a copy of the posting in the social service office and would locate it as soon as the social service staff arrived at work.
During the group meeting on 10/13/11 at approximately 2:30pm, there were 10 residents in attendance and none of the residents knew where the Medicaid and Medicare information is posted.
On 10/14/11 at approximately 10:30am, E1 told survey team that the Medicaid and Medicare services were not posted because residents always removes the postings from the assigned location,

B. Based on closed record review and interview, the facility failed to have clear and consistent documentation for advanced directives for one of one resident (R30) in a sample of 30 residents reviewed for advanced directives.

Findings include:

The closed record documents note that R30 was admitted to the facility on 6/15/09. The admission face sheet is missing all information regarding advanced directives. The Illinois Department of Public Health (IDPH) Uniform Do-Not Resuscitate (DNR) Order Form dated 10/5/09 signed by R30 indicates a "do not attempt cardiopulmonary resuscitation (CPR)." A Power of Attorney (POA) for Health Care was signed by R30 on 10/5/09, assigning a family member as power of attorney for medical decision making. The Physician's

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F 156	Continued From page 4 Order Sheet (POS) dated 8/1/11 lists R30 as Full Code status. R30 was seen in the emergency room on 8/8/11 following a choking/aspirating incident which led to her going into respiratory arrest. Hospital emergency room records dated 8/8/11 states that a decision was made to intubate R30 because the DNR did not apply and because there was a discrepancy between R30's DNR pink sheet and the information received from the POA. On 10/13/2011 at 10:30am ,E2 (Director of Nurses) was present when R30's advanced directive status was discussed. E2 informed the survey team that advanced directives status is determined when residents are first admitted to the facility. E1 (Administrator) was asked for a clarification on R30's Advanced Directives on 10/13/11 at 10:30am. E1 offered no explanation nor did E2 offer an explanation.	F 156		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal	F 159		11/11/11

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F 159	Continued From page 5 funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the residents and/ or resident's family when the trust fund balances were within $200 of the SSI limits. This failure occurred for three residents(R31, R32, R33) in the supplemental sample.	F 159		

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F 159	Continued From page 6 Findings include: A review of the resident's trust fund accounts revealed that there were three residents (R31,R32,R33) whose trust fund monies were within the $200 SSI maximum limit of $2000. R31 funding status is Medicare/medicaid and the trust fund balance is $1922.96. R32 funding status is medicaid and the trust fund balance is $1935.35. R33 funding status is medicaid and the trust fund balance is $1927.13. On 10-13-2011 at 11:50am Z#7, the Corporate comptroller stated that she was not aware that the residents and/or family member must be informed when funds reached $200 of the limit which would be $1800 balance in the trust fund . Z#7 said she thought notification was made WHEN they reached $2000.00 Z#7 said that she did not tell R33 who is very alert about the regulatory requirement. She also admitted that R31 and R32 families were not informed. She said the Korean families do not want to touch the resident monies.	F 159		
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have a surety bond with dollar limits that	F 161		11/11/11

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F 161	Continued From page 7 cover that maximum amount of monies held in the resident's trust fund account. This failure occurred for 24 of 30 residents(R1,2,4,6,7,8,9,10,11,12,13,14,15,16,17, 18,20,21,22,23,24,25,27,28) reviewed for monies held by facility in a trust fund account. This has the potential to affect the 161 medicaid and 6 medicare residents residing in the facility. Findings include: Review of the list of resident funds thru 10/11/2011 -R1,2,4,6,7,8,9,10,11,12,13,14,15,16,17,18,20,21 ,22,23,24,25,27 and R28 have monies held by the facility. On Tuesday, 10-11-2011, the facility presented a Surety bond that covers the monies in the resident trust fund account. The bond titled, Certificate of Property Insurance showed a policy limit of $80,000 for the patient funds bond. The policy effective dates were listed as 06/10/2011 to 06/10/2012. The documents presented by E1(Administrator) on 10-13-2011 were the third quarter balances maintained at the local banking institution. The resident trust fund account balances EXCEEDS the $80,000 dollar limit of the Surety Bond. The balances are: Sept. 30, 2011- $96,869.44 Aug. 31, 2011- $95,389.57 July 31, 2011- $ 92,680.51 The bank statements are not titled the Niles Nursing & Rehabilitation Center Resident Trust account, it only lists the facility's name..	F 161		

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F 161	Continued From page 8 Z#7, the corporate comptroller consultant confirmed during interview on 10-13-2011 at 12pm that the bank statements presented were the resident trust fund accounts . E1(Administrator) said on 10-13-2011 at 4:30pm that he had to check with his corporate office regarding the bond.	F 161		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		11/11/11

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F 225	Continued From page 9 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: A. Based on record review and interview, the facility failed to follow its Abuse policy for reporting to the State agency and failed to investigate resident's injuries of unknown origin for one resident (R9) and an unusual occurrence for one resident (R30) out of 9 residents reviewed for abuse/mistreatment in a sample of 30. R30 had a choking incident while being fed by staff during a meal. Findings include: 1. R30's closed record review on 10/13/11 reveals nursing notes dated 8/8/11 at 5:45pm stating R30 turned blue during evening meal, was sent to hospital and admitted with a diagnosis of respiratory failure. There was no report of this incident found in facility's Incident/Accident Log. E1 (Administrator) and E2 (Director of Nursing, DON) were asked to provide survey team with evidence that an incident report was completed and the incident being reported to the State Agency. On 10/14/11 at approximately 10:30am, E2 told survey team that an incident report and investigation were not completed and the facility did not feel the incident needed to be reported to	F 225		

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F 225	Continued From page 10 the State Agency because it was a 'medical emergency.' Review of R30's hospital record for this incident shows R30 expired in the hospital 30 hours after choking during the consumption of the evening meal. 2. Review of facility Incident/Accident reporting log dated October 2010 through October 2011, shows an incident dated 5/15/11 which describes R9 found with a bruise of unknown origin on the left hand. There was no evidence of an investigation nor reporting to the State Agency found. E2 was asked by the survey team to provide this evidence on 10/13/11. E2 told survey team on 10/14/11 at 10:15am, that this incident was neither investigated nor reported to the State Agency. B. Based on observation, interview and record review, facility failed to report to the State agency the initial and final investigation reports involving one resident(R20) of 30 in sample reviewed for fall incidents. As a result, this resident was sent to the hospital for a change in condition / injury requiring treatment in hospital. The facility failed to fully invesigate incident involving one resident who sustained an injury and sent out to hospital for treatment. Findings include: Incident report dated 10/3/11 at 11:00 AM, indicates R20 sustained a fall due to mental status change. Incident report indicates interview with RN who reported resident to be lethargic in the AM, sleeping in chair next to nursing station. Report investigation indicates RN reported	F 225		

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F 225	Continued From page 11 resident found in his room on the floor in supine position at 2:20 PM and that resident was unable to state what he was doing at the time. Report indicates resident is an independent ambulator(Assistive device-wheelchair not applicable). On 10/12/11 at 3:50 PM, E2(Director of Nursing) indicated that incident of fall leading to hospitalization was not reported to State Agency (IDPH) on 10/3/11 and nor was a final investigation of incident reported to IDPH regarding R20's fall . R20 suffered a hematoma and was treated at a local hospital. Physician's order dated 9/1/11 through 9/30/11 indicates admitted on 7/23/11 with diagnosis to include; Parkinson's Disease; Depression; Senile Dementia; Diabetes; Hypertension; Paralysis Agitans. On 10/12/11 at 3:50PM, E2(DON), indicated incident on 10/3/11 involving R20 was not submitted to IDPH. Fax document (Incident investigation and final investigation) dated 10/12/11 at 7:01PM was submitted to IDPH.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: A.Based on observation, interview and record review the facility failed to implement its Abuse	F 226		11/11/11

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policy to investigate and report verbal abuse/mistreatment of their residents by an outside visitor to the State survey agency for 2 of 30 residents (R14 and R12) and two residents (R34 and R35) in the supplemental sample reviewed for the abuse protocol. The Abuse policy also includes language regarding not reporting to the State agency an altercation between residents that have dementia or a developmental disability.
Findings include:
1. During an interview on 10/11/11 at 3:45pm with R14 and R12, Z1(visitor) barged into R14s room without knocking. Z1 (Family Member of R36) began yelling what are you saying about my son (R36)? R14, who was intimidated stated, " nothing. " Z1 (Family Member of R36) then stated, " they (R14 and R12) are always looking for soda. " R14 and R12 responded that it was not them. Surveyor introduced self to Z1 (Family Member), who then exited abruptly. R14 stated that Z1s (Family Member) behavior was upsetting. " Barging in without knocking, most people knock before coming in. She was interrupting us, yelling without knocking. " On 10/11/11 at 4:25pm the above incident was reported to E2 (Director of Nursing). The incident was reported to state agency (Public Health) on 10/11/11 at 13:14.
2. On 10/13/11 at 11:45pm E7 (Social Service) stated she was aware of " several incidents involving Z1. " E7 (Social Service) stated that Z1 was " verbally harassing " R3 sometime in May. On 5/4/11 at 5pm the Social Service Progress Notes of R35 stated, " Resident expressed concern re: feeling uncomfortable w/co-resident ' s mother in the dining area due to outside incidences w/daughter. This writer alerted

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resident that his concern was already addressed and that co-resident will visit w/mother in designated area. " On 5/2/11 the Social Service Progress Notes of R36 (mother of Z1) states, " Service Note: Resident ' s mother had been observed exhibiting verbal aggression toward son ' s peer. Resident ' s mother has been notified that due to her behavior she may only visit with resident in the lobby area supervised by the Receptionist until behavior is noted as improved. Resident ' s mother agreed that she understands. " On 6/17/11 the Social Service Progress Notes of R36 stated that Z1 (Family Member), has visited " 4-6 times since the restriction was placed and her behavior has noticeably improved. She will refrain from exhibiting negative verbal behaviors toward any residents. As a result, resident ' s mother is now able to visit with resident in his room and other parts of the facility. " On 10/13/11 at 4:50pm E35 stated that Z1 (Family Member), was causing trouble and that he was staying away from the family. When she is on the floor, I stay in another room until she leaves. R35 stated he didn' t want any trouble. E7 (Social Service) did not report the incident to anyone. This incident was not reported to the state agency (Public Health).

3. E7 (Social Service) continued to discuss two separate incidents with R34. According to E7, the first incident occurred a few weeks ago. E7 (Social Service) stated that R34 has dementia and at times curses inappropriately. " Z1 (Family Member), has gotten aggravated with R34, because he ' s called her a c ... " On 10/13/11 at 2:40pm R34 was asked if he had any problems with family members at the facility. He stated, " oh yeah that b ...., R36s mom. " R34 refused to elaborate and stated, " I don' t want to say. "

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Social Service Progress Notes dated 8/10/11 documented the incident. On 8/19/11 at 5pm Social Service Progress Notes state, "update: Co-resident ' s mother was restricted to supervised visits in the main lobby of facility for one week due to behavior. Co-resident ' s mother expressed compliance with restriction. Restriction lifted after 1 week due to appropriate visits. Social service to monitor and assist as needed. " E7 (Social Service) reported the incident to E11 (Social Service) who did not report the incident to anyone. This incident was not reported to the state agency (Public Health). The second incident according to E7 (Social Service) occurred when Z1 (Family Member) accused R34 of hitting her son during the residents smoking break. E7 (Social Service) confirmed through the facility ' s smoking monitors that the incident never occurred. She relayed this information to Z1 (Family Member), whose only response was that everyone at the facility had an attitude. E7 (Social Service) stated that the incident was not reported to anyone because Z1 (Family Member) told her she had already spoken to E2 (Director of Nursing). E1 (Administrator) on 10/13/11 at 12:25 stated he was aware of an incident with Z1 (Family Member) in summer, but could not recall the incident. E1 (Administrator) stated, " Z 1 (Family Member) is here quite a bit, she has a huge mouth and is abusive to everyone else who is not good to her son. She threatened R34. I ' m not sure why it happened. I don ' t remember when it happened, it may have been last week. " E1 (Administrator) stated he found out about the incident from Z1 (Family Member) and in a morning staff meeting. He did not remember the incident or what Z1 (Family Member) told him.

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F 226	Continued From page 15 He stated he did not report the incident to the Department of Public Health. E1 (Administrator) was unaware of any other incidents involving Z1 (Family Member). E2(Director of Nurses) on 10-13-2011 at 5:15pm apologized and said that once she became aware of the incident, she did not report the incident. The facility ' s policy " ABUSE PREVENTION PROGAM " dated 02/07/2011 states: " VI. Protection of Residents -The facility will take steps to prevent mistreatment while the investigation is underway. -Residents and visitors are protected from any retaliation or possible harm. -Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation. " The policy further states: "ABUSE REPORTING: For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. 2. Verbal Abuse: Any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. " 4.The policy indicates that residents with dementia or developmental disability will NOT be reported. The policy states: "PROCEDURE: Abuse involving one resident upon another	F 226		

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F 226	Continued From page 16 resident will be reported to IDPH except in situations where the behavior is associated with dementia or developmental disability. " B.Based on interview and record review the facility failed to implement its Abuse policy by training and educating staff regarding the Abuse Coordinator. This has the potential to affect the residents who reside on the third and fifth floors of the facility. Findings include: When conducting the Abuse protocol the following staff did not answer appropriately when asked if could identify the Abuse coordinator of the facility. E6 (Registered Nurse) on 10-11-2011 at 11:05 am gave no response. E6 works on the 5th floor. E7 (Social Services) on 10-13-2011 at 11:20am said she did not know. E8(Certified Nurse's Assistant-CNA) on 10-13-2011 at 2:30pm said the Director of Nurses. The Policy states in accordance with Niles Nursing and Rehabilitation Center Abuse Prevention Policy and Procedure, the Administrator, E1, is the Abuse Coordinator.	F 226		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		11/11/11

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This REQUIREMENT is not met as evidenced by:
A. Based on observation and interviews, the facility failed to place call lights within reach of 2 of 30 sampled residents (R2, R8) and one resident (R37) in the supplemental sample.

Findings include:

1. During the initial tour of the facility's 4th floor on 10/11/11 at approximately 9:30am with E21 (Nurse), R2 was sitting up in a geriatric chair, alert appearing, with gasrtic tube feeding in progress. E21 told surveyor that R2 is non-verbal and unable to make her needs known. R2's call light was not within reach. The Physician's Order Sheet (POS) states R2 is on safety precautions due to poor trunk control, safety awareness and poor posture. The Minimum Data Set (MDS) shows R2 requires extensive to total assistance for all activities of daily living.

2. During the initial tour of the facility on 10/11/11 at approximately 9:15am with E21, R8 was observed sitting in her room in a wheel chair. R9 told surveyor that she is not able to toilet herself and requires staff assistance. R8 went on to say that when she needs assistance she uses the call light to get help. E21 told surveyor that R8 has a history of falls and is on fall risk precautions. R8's call light was not within her reach.

3. On 10/11/11 at approximately 9:20am, R37 was observed in bed, awake. R37 appeared alert and speaking in a foreign language. E21 stated

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F 246	Continued From page 18 that R37 speaks Korean only, and requires limited assistance with activities of daily living. R37's call light was not within her reach. B. Based on observation and interview, the facility failed to have accessible call light in the shower rooms on 2 of 4 floors (3rd, 4th). This failure affects 19 residents (R1, 2R3, R4, R5, R7, R8, R9, R12, R13, R14, R15, R16, R17, R18, R21, R22, R23, R24, R27) in a sample of 30. There are 147 residents residing on these 2 floors. Findings include: During the environmental tour with E22 (Maintenance Director) and E23 (Housekeeping Director) on 10/11/11 at approximately 11:30am, the 4th floor has 2 shower stalls. The call light in both stalls has short cords, approximately 2-3 inches long, attached. E22 stated that the shower stalls were recently remodelled and there is a plan in place to attach new call light cords. At approximately 11:45am, one of the two shower stalls on the 3rd floor had a short call light cord and the second stall had a missing call light cord. E22 stated that he will replace the cords as soon as possible. E1 (Administrator) told survey team on 10/11/11 at approximately 4:30pm, that residents on the 3rd and 4th floors removes the cords and maintenence staff keeps replacing them. E1 went on to say that an extra supply of call light cords will be kept on each floor.	F 246		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		11/11/11

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This REQUIREMENT is not met as evidenced by:
Based on closed record review and interview, the facility failed to document swallowing difficulty concerns, conduct a comprehensive swallow evaluation and failed to access emergency response for one resident (R30) in a sample of 30 residents. R30 has a history of coughing while being fed, choked and aspirated food and sent out for emergency treatment 2 hours later. R30 expired approximately 30 hours later.

Findings include:

R30's closed record review on 10/13/11 reveals nursing notes dated 8/8/11 at 5:45pm stating R30 turned blue during evening meal, was sent to hospital and admitted with a diagnosis of respiratory failure. Previous nursing documentation dated 7/18/09 through 7/12/11 states R30 has had no problems during feeding.
The Physician's Order Sheet (POS) dated 3/22/11 shows an order for swallow evaluation. There was no documentation found to support need for a swallow evaluation.
Physician's Progress notes dated 2/10/10 through 7/13/11 makes no reference to any concerns with food and/or liquid ingestion.
Nursing Care Plan dated 4/4/11 states R30 demonstartes some risk to potentially choke/aspirate foods or liquids due to general problems with chewing and/or swallowing.
The Minimum Data Set (MDS) dated 6/17/11 states R30 requires extensive assist with meals, with one-person physical assist.
Dietary notes dated 6/17/11 shows R30 on a

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F 281	Continued From page 20 pureed diet with honey thick liquids. Speech Therapy notes dated 3/22/11 shows R30 assessed by E20 (Speech Therapist) in response to referral from nursing staff. The screen states "referral requested diet change. Pt. (patient) displayed difficulty in eating and swallowing diet w/ (with) hard swallows and c/c ing (choking/coughing) at lunch." During an interview with E20 and E19 (Speech Therapist) on 10/14/11 at 2:15pm, E20 confirmed that she did assess R30 on 3/22/11. When asked if her assessment constitutes a swallow evaluation, E20 responded that the order for swallow evaluation was unclear, and that she did not know whether the ordering physician wanted an internal swallow evaluation or an external evaluation. E20 went on to say that she conducted an external evaluation which consisted of 1:1 feeding with close observation of R30. E20 stated that R30 was choking and coughing during the screen and she (E20) recommended a downgrade in food consistency from general to puree. E20 stated that in her opinoin, there was no need for further screening. E20 also stated that she did not make any recommendations for further monitoring of R30's tolerance of the new food consistency. E20 stated that if R30 was not tolerating the pureed consistency the department would have known that. According to E20, speech therapy monitors luch meals for all residents with swallowing concerns. E20 described R30 as a self-feeder and when noted to be slow in eating, would receive assist with feeding. E19 stated during this same interview that she (E19) is not familiar with R30, and went on to say that the facility's policy is to monitor residents with swallowing concern on three occasions over a	F 281		

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two week period to see how these residents are tolerating the new food consistency. Neither E19 nor E20 knew if R30 was monitored per facility's policy. Both E19 and E20 stated that the therapist who may have monitored R30 no longer works at the facility and were unable to provide documentation to support R30 being monitored.

E24, Nurse, was the nurse that took care of R30 during the choking incident. E24's documentation dated 8/8/11 at 5:45pm states R30's face turned blue and she suctioned R30 and conducted an assessment of R30's vital signs. The documentation goes on to state that she (E24) administered Oxygen by nasal cannula at a rate of 3 liters per minute and the physician was notified, who ordered that R30 be transferred to the hospital and given Tylenol for an elevated temperature. The notes states that the ambulance service was call (no time indicated). According to E24's notes, the ambulance service arrived at 6:45pm to transfer R30 to the hospital. A subsequent note at 7:30pm states ambulance service called to say R30 would be taken to the nearest hospital. At 10pm, E24 wrote that R30 was admitted to the hospital with a diagnosis of respiratory failure.

During an interview with E24 on 10/14/11 at 3pm, E24 requested E2's (Director of Nursing, DON) presence during interview. E24 stated that she was in the same dining room with R30, she heard R30 coughing, immediately told the certified nurses aid (CNA) to stop feeding R30, and immediately went over to R30, immediately supported R30's chest and patted R30 on the back. According to E24, R30 was turning blue and she (E24) began suctioning R30 with a

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F 281	Continued From page 22 suction that was next to R30 in the dining room. E24 stated she believed there was something in R30's airway obstructing her breathing. During the interview E24 could not recall how long she was suctioning R30, thinks she suctioned for more than 15 minutes, and that R30's skin color returned to normal, and with the assistance of E25 (CNA), transported R30 to her room and transferred her to bed. Once in bed, E24 assessed R30's vital signs, discovered that R30 had a temperature of 101 degrees farenheit and called then physician. E24 stated she could not recall at what time she called the ambulance service but remembers the service arrived very quickly, within 1-5 minutes. E24 stated that she did not call 911 emergency service because R30's condition had improved. E25 (CNA) was interviewed on 10/14/11 at 4:15PM. E25 requested that E2 (DON) be present during the interview. E25 speaks very little English (Korean speaking) and E26 (Accounting Conlultant) was present as translator. E25 stated she was feeding R30 and 2 other residents when R30 began to cough, 3-4 coughs. When asked to demonstrate the type of cough, E25 demonstrating a choking cough. E25 stated she asked E24 if she should stop feeding R30 and E24 told her to stop. E25 stated the cough was different from the usual. E25 said while E24 was suctioning R30, she, E25, held R30's shoulder to maintain R30 in an upright position. E25 stated that R30 often leans to the side due to poor trunk control. E25 could not remember what R30's posture was like during feeding and coughing. E25 confirmed that she assisted E24 in transferring R30 back to bed where she (E25) remianed with R30 for 30-40 minutes until ambulance service came. E25	F 281		

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F 281	Continued From page 23 stated she was concerned that R30 would have choked again. E25 stated that she assist R30 with evening meal on the 3-11 shift daily and that R30 would cough during meals about 2-3 times each week. E25 stated when this occurs she monitors R30 to see how long cough would continue. During an interview with Z6 on 10/13/11 at 10:30am, Z6 stated that E24 requested that R30 be transported to an affliate hospital and a decision was made by the ambulance service to take R30 to the nearest hospital instead. Z6 stated that upon arrival at the facility, R30 was non-responsive. The emergency service reports states the facilty called for service at 6:42pm, one hour after R30 choked on her food.	F 281		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 285		11/11/11

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F 285	Continued From page 24 (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide complete PASSR (Psychiatric Assessment Screening Report) for one (R16) of 21 resident reviewed for serious mental illness out of 30 sampled residents. The resident was diagnosed with severe mental illness but not assessed by a State Agency for SMI (severe mental illness). Resident did not receive treatment for severe mental illness (Bipolar Disorder) at the facility.	F 285		

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F 285	Continued From page 25 Findings include: On 10/11/11 at 10:45AM, R16 stated that residents curse at other residents and staff. He has reported this to staff and administration. R16 stated he does not attend groups or activities because he is not interested. On 10/13/11 at 2:40PM, E11(Case Manager), stated R16 did not attend anger management group as recommended and that resident has a history of none compliance with treatment. On 10/14/11 at 12:50PM, E4(Minimum Data Set coordinator) stated she had not seen a PASSR screen before and does not include that information in the MDS annual or quarterly assessments because she has no knowledge of it. On 10/14/11 at 1:45PM, E12 (Social Services Director) stated he did not have knowledge of a PASSR screen or OBRA for SMI (severe mental illness). E12 stated he makes psychosocial treatment plan based on the Doctor's diagnosis. E12 stated he reported residents behaviors to the doctor and believed the diagnosis was based on that and what other staff reported about R16. On 10/12/11 at 3:40PM, E2(DON), indicates resident did not have SMI assessment. Physician orders dated 10/11/11 indicates R16 admitted to facility on 4/6/08 with Diagnosis of Hypothyroidism, Cellulitis, Pacemaker, Mild Occlusion, Vascular Disease.	F 285		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/11/11

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This REQUIREMENT is not met as evidenced by:
A. Based on closed record review and interview, the facility failed to monitor, assess and initiate emergency response services for one resident (R30) in a sample of 30, who went into respiratory arrest following a choking incident during dining. R30 was transported to the emergency room approximately 2 hours after choking incident, intubated in the emergency room and subsequently expired 30 hours later.

Findings include:

R30's closed record review on 10/13/11 reveals nursing notes dated 8/8/11 at 5:45pm stating R30 turned blue during evening meal, was sent to hospital and admitted with a diagnosis of respiratory failure. Previous nursing documentation dated 7/18/09 through 7/12/11 states R30 has had no problems during feeding.
The Physician's Order Sheet (POS) dated 3/22/11 shows an order for swallow evaluation. There was no documentation found to support need for a swallow evaluation.
Physician's Progress notes dated 2/10/10 through 7/13/11 makes no reference to any concerns with food and/or liquid ingestion.
Nursing Care Plan dated 4/4/11 states R30 demonstartes some risk to potentially choke/aspirate foods or liquids due to general problems with chewing and/or swallowing.
The Minimum Data Set (MDS) dated 6/17/11 states R30 requires extensive assist with meals, with one-person physical assist.

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F 309	Continued From page 27 Dietary notes dated 6/17/11 shows R30 on a pureed diet with honey thick liquids. Speech Therapy notes dated 3/22/11 shows R30 assessed by E20 (Speech Therapist) in response to referral from nursing staff. The screen states "referral requested diet change. Pt (patient) displayed difficulty in eating and swallowing diet w/ (with) hard swallows and c/c ing (choking/coughing) at lunch." During an interview with E20 and E19 (Speech Therapist) on 10/14/11 at 2:15pm, E20 confirmed that she did assess R30 on 3/22/11. When asked if her assessment constitutes a swallow evaluation, E20 responded that the order for swallow evaluation was unclear, and that she did not know whether the ordering physician wanted an internal swallow evaluation or an external evaluation. E20 went on to say that she conducted an external evaluation which consisted of 1:1 feeding with close observation of R30. E20 stated that R30 was choking and coughing during the screen and she (E20) recommended a downgrade in food consistency from general to puree. E20 stated that in her opinoin, there was no need for further screening. E20 also stated that she did not make any recommendations for further monitoring of R30's tolarance of the new food consistency. E20 stated that if R30 was not tolerating the pureed consistency the department would have known that. According to E20, speech therapy monitors luch meals for all residents with swallowing concerns. E20 described R30 as a self-feeder and when noted to be slow in eating, would receive assist with feeding. E19 stated during this same interview that she (E19) is not familiar with R30, and went on to say that the facility's policy is to monitor residents with	F 309		

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swallowing concern on three occasions over a two week period to see how these residents are tolerating the new food consistency. Neither E19 nor E20 knew if R30 was monitored per facility's policy. Both E19 and E20 stated that the therapist who may have monitored R30 no longer works at the facility and were unable to provide documentation to support R30 being monitored.

E24, Nurse, was the nurse that took care of R30 during the choking incident. E24's documentation dated 8/8/11 at 5:45pm states R30's face turned blue and she suctioned R30 and conducted an assessment of R30's vital signs. The documentation goes on to state that she (E24) administered Oxygen by nasal cannula at a rate of 3 liters per minute and the physician was notified, who ordered that R30 be transferred to the hospital and given Tylenol for an elevated temperature. The notes states that the ambulance service was call (no time indicated). According to E24's notes, the ambulance service arrived at 6:45pm to transfer R30 to the hospital. A subsequent note at 7:30pm states ambulance service called to say R30 would be taken to the nearest hospital. At 10pm, E24 wrote that R30 was admitted to the hospital with a diagnosis of respiratory failure.

During an interview with E24 on 10/14/11 at 3pm, E24 requested E2's (Director of Nursing, DON) presence during interview. E24 stated that she was in the same dining room with R30, she heard R30 coughing, immediately told the certified nurses aid (CNA) to stop feeding R30, and immediately went over to R30, immediately supported R30's chest and patted R30 on the back. According to E24, R30 was turning blue

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F 309	Continued From page 29 and she (E24) began suctioning R30 with a suction that was next to R30 in the dining room. E24 stated she believed there was something in R30's airway obstructing her breathing. During the interview E24 could not recall how long she was suctioning R30, thinks she suctioned for more than 15 minutes, and that R30's skin color returned to normal, and with the assistance of E25 (CNA), transported R30 to her room and transferred her to bed. Once in bed, E24 assessed R30's vital signs, discovered that R30 had a temperature of 101 degrees farenheit and called then physician. E24 stated she could not recall at what time she called the ambulance service but remembers the service arrived very quickly, within 1-5 minutes. E24 stated that she did not call 911 emergency service because R30's condition had improved. E25 (CNA) was interviewed on 10/14/11 at 4:15PM. E25 requested that E2 (DON) be present during the interview. E25 speaks very little English (Korean speaking) and E26 (Accounting Conlultant) was present as translator. E25 stated she was feeding R30 and 2 other residents when R30 began to cough, 3-4 coughs. When asked to demonstrate the type of cough, E25 demonstrating a choking cough. E25 stated she asked E24 if she should stop feeding R30 and E24 told her to stop. E25 stated the cough was different from the usual. E25 said while E24 was suctioning R30, she, E25, held R30's shoulder to maintain R30 in an upright position. E25 stated that R30 often leans to the side due to poor trunk control. E25 could not remember what R30's posture was like during feeding and coughing. E25 confirmed that she assisted E24 in transferring R30 back to bed where she (E25) remianed with R30 for 30-40	F 309		

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F 309	Continued From page 30 minutes until ambulance service came. E25 stated she was concerned that R30 would have choked again. E25 stated that she assist R30 with evening meal on the 3-11 shift daily and that R30 would cough during meals about 2-3 times each week. E25 stated when this occurs she monitors R30 to see how long cough would continue. During an interview with Z6 on 10/13/11 at 10:30am, Z6 stated that E24 requested that R30 be transported to an affliate hospital and a decision was made by the ambulance service to take R30 to the nearest hospital instead. Z6 stated that upon arrival at the facility, R30 was non-responsive. The emergency service reports states the facilty called for service at 6:42pm, one hour after R30 choked on her food.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services to reassess the necessity of the feeding tube for two of five residents (R4 and R5) reviewed for gastrostomy tubes in a sample of 30.	F 322		11/11/11

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F 322	Continued From page 31 Findings include: On 10/11/11 between 10:00am and 10:15am on the initial tour of the facility, tube feedings were infusing in the gastrostomy tubes of R4 and R5. Record review showed under Therapy Orders for R4 and R5, an order for a swallow evaluation to be done every 6 months. The last swallow evaluations for R4 and R5 were completed on 3/17/11 and 10/11/10 respectively. On 10/12/11 at 12:10pm E9 (Speech Therapist) stated, " my understanding is the nurse is to resend the order, we do not generate the order. " On 10/13/11 at 5:25pm E10 (Dietician) stated that swallow evaluations are completed " to see if they can progress from NPO (nothing orally) to eating. Some of them have potential. There is always a potential. " On 10/14/11 at 10:30am, the facility presented two different types of paperwork from speech therapy, "Speech Therapy Initial Evaluation and Therapy Screen." During status with the facility at 12:25 pm on 10/14/11, E2 (Director of Nursing) stated, "they're not the same."	F 322		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		11/11/11

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F 329	Continued From page 32 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to have definitive diagnoses for the usage of psychoactive, antibiotic and laxative medications and stop date for an antibiotic medication, for 4 of 30 sampled residents (R6, R11, R15 and R18), and 2 in the supplements sample(R40 and R41). Findings Include: 1). R11 was observed walking in the hallway independently carrying a cup. R11 spoke/responded appropriately when spoken to. R11's admission records notes, R11 is a 55 year old male re-admitted to the facility on 9-23-11 with diagnoses of paranoid schizophrenia, anemia, obesity, nicotine abuse and hypertension. Review of R11's medications admission records notes lorazepam 1mg (antianxiety) by mouth at	F 329		

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bedtime. This medication was ordered on 9-27-11. There are no medical reason as to why R11 is currently being given anti- anxiety medication.

E16 (staff nurse) stated on 10-12-11 at 2:00 PM, R11 has been requesting something for sleep frequently to the evening nurses. The evening nurses explained this to E16 that this order is for insomnia.

Z2 (United Pharmacy) stated on 10-12-11 at 2:30PM, R11 has no diagnosis to sustain getting an antianxiety, (Lorazepam).

2). R41 was observed on 10-14-11 at 1:00 PM in her room brushing her teeth. R41 had just finished eating lunch.

Review of R41's physician order sheet notes dated 9-22-11 Permethrin 5% (scabicide/pediculicide)topically from head to toe, then wash off between 8 to 10 hours. May be repeated after 10 days.

Research of the entire clinical records with assistance by E16 and E17 there are no symptoms documented for use of scabicides or documentation for prophylactic reason. No assessments of contamination from other residents for the purpose of scabicide topically cream.

E17 (staff nurse) and E18 (staff nurse) stated on 10-12-11 the Nurse Practitioner gave orders for the use of scabicides and reasons, but the documentation could not be found by E17 and E18.

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F 329	Continued From page 34 E15 (Nursing PM Supervisors) stated on 10-12-11 that the facility's Nurse Practitioner no longer works at the facility because of payments. 4 (R 41' s' Attending Physician) stated on 10-12-11 at 2:45 PM," he was not aware of any such medication orders nor was he aware of any out breaks of scabies in the facility. 3). R40 was observed eating lunch in the dining room independently. Review of R40's physician orders sheets notes permethsin 5% (scabicides/pediculicide) topically, use head to toe, and wash off between 8 to 10 hours. May be repeated in 10 days. Research of the entire clinical records assisted by E17 and E18, there are no symptoms documented in the clinical records or lab results of a diagnosis of scabies. There are is no documentation in the clinical records noting the reasons for prophylactic use... Z3 (R40 ' s Attending Physician) stated on 10-12-11 at 3:00PM, " I was not aware of the medication being order, nor was I aware of any outbreaks of scabies in the facility " I do not believe R41 had it, it was just use for prophylactic reasons, I hope." E2 (Director of Nursing) stated on 10-14-11 at 11:30AM in front of the entire survey team," the nurse that order the medication for R40 and R41 did not document the reasons nor symptoms, and I do not know why that nurse did that. I believed it was used prophylactically for one but the other	F 329		

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F 329	Continued From page 35 resident did have scabies. E2 had no lab results for a definitive diagnosis for scabies for both R40 and R41. 5). R18 was observed sitting on his bed with a foul body odor, looking at a book. Review of R18's admission records notes R18 is a 56 year old male admitted to their facility on 5-22-07 with the diagnoses which includes constipation, renal failure, hypertension and urinary retention. Review of R18's medications administration records notes the following: senna plus 8.6, 2 tabs by mouth every morning metamucil powder 1tablespoon at dinner senna 1 tab 8.6mg every evening miralax 1 cap fill every morning. R18 is administered 3 different medications 4 times daily for the treatment of constipations. Review of the R18's clinical records notes no documented reasons for an excessive use of laxatives. E16 (staff nurse) stated on 10-12-11 at 3:30PM gave an explanation that R18 had problems in the past with constipation but currently has no problems. Z2 (Pharmacist) stated on 10-12-11 at 3:45PM," the amount of medication R18 is receiving "quite a bit." for constipation. E2 (Director of Nursing) explained on 10-14-11 at 11:30PM, R18 has had severe medical issues with constipations and was hospitalized in 2009.	F 329		

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F 329	Continued From page 36 His family does not want R18 taken off of the 3 different medications 4 times a day because of what happen 3 years ago. This is why it has not been changed. Review of the facility's policy, "Policy and Procedure Suspicious Rashes" (not dated) notes: 1). Assess the rash that has been identified, 2). Notify resident's MD with descriptions of the rash. 3). 4). Initiate contact precautions if scabicide has been ordered throughout the durations of the scabcidie. Review of the facility ' s policy "Procedure Suspicious Rashes " none of the components were implemented for R40 and R41. 7. On 10/13/11 at 11:45 AM, Physician Order Sheet (POS) indicated that R6 receives multiple laxatives on a regular schedule. The laxatives are as follows: - Polyethylene Glycol 1 capful (17 gram) in 8 ounce of water and take by mouth once daily. - Senna Tab 8.6 milligram (mg). Take 2 tablets (17.2 mg) by mouth at bedtime. - Docusate Sodium 100 mg. Take 1 capsule (100 mg) by mouth three times daily. The POS and Face Sheet Information has no diagnosis of constipation. On 10/14/11 at at 9:15 AM, E17 Registered Nurse (RN) stated, she paged Z5 MD (Medical	F 329		

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F 329	Continued From page 37 Doctor) for clarification of medication purpose and will follow up with surveyor. As of 10/14/11 at 3:00 PM, there is no follow up response from E17. 8. On 10/13/11 at 10:00 AM, review of POS of R15 for October 2011 indicated, Erythromycin ointment apply to left eye every six hours. Medication was ordered on September 24, 2011 no stop date was indicated. On 10/13/11 at 2:23 PM, E14 Registered Nurse stated, the Erythromycin ointment was being given for R15's conjunctivitis. The conjunctivitis is resolved and the stop date was overlooked.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain sanitary conditions in the kitchen by incorrect use of sanitizing agents for the dishes, food prep areas and elimination of insects from the kitchen during food preparation. This potentially affect the 265 residents who eats in the facility.	F 371		11/11/11

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F 371	Continued From page 38 Findings include: 1. On 10-11-11 at 9:30AM, during initial kitchen tour with E13 Dietary Manager, the dish washing machine area has standing water in the grout tiles on the floor. The metal food carts in the hold area of the kitchen were wet. There were insects, flying over the stove and prep table, the dish washing area and the hold area for the mobile food carts. E13 stated on 10-11-11 at 10:30AM, the exterminator came last week and gave several recommendations to get rid of the flying insects. We have much more work in the kitchen about the fruit flies. The exterminator's recommendations dated 9-30-11are as follows: 1). Close the hole in the wall under the dish sink. 2). Keep the metal food carts in the holding area dry. 3). Keep the floor tile clean and dry. All of these eliminate the flying nits in the kitchen. Genefe Teodoro: 2. On 10/12/11 at 8:50 AM, during kitchen observation, the rack for clean plates has a lot of debris particles, the inside was sticky to touch, with old brown stain substances, there was an empty crumpled substitute sugar wrapper inside the plate rack. Clean plates was stack inside this rack.	F 371		

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F 371	Continued From page 39 3. The floor was dirty with debris particles all over. 4. The facility uses chlorine as sanitizing agent for the three compartment sink and the dish washing machine. On 10/13/11 at 12:40 PM, the chlorine concentration level to both three compartment sink and the dish washing machine was 200 parts per million (ppm). E13 Dietary Manager stated, the acceptable level for chlorine is about 50- 150 ppm. The range they aimed for is 50-150 ppm, but the range for chlorine sanitizer is still safe at 200 ppm. Review of the sanitizer test procedure indicates that the required level for Chlorine is 100 ppm.	F 371		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have firmly secured hand rails on 1 of 4 floors (4th). This deficient practice has the potential to affect 5 residents (R2, R7, R8, R9, R27) in the sample of 30 residing on this floor. There are 74 residents housed on this floor. Findings include: During the environmental tour with E22 (Maintenance Director) and E23 (Housekeeping Director) on 10/11/11 (day 2 of the survey) at approximately 11:45am, the hand rails on the 4th	F 468		11/11/11

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F 468	Continued From page 40 floor between the shower room and the nurses station was loose and not secure to the wall. E22 stated that he was not aware of this and would secure them as soon as possible. During the first two days of the survey residents were observed ambulating on the unit with walkers and without assistive devices for ambulating.	F 468		
F9999	FINAL OBSERVATIONS FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.690a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents	F9999		

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F9999	Continued From page 41 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on closed record review and interview, the facility failed to document swallowing difficulty concerns and conduct a comprehensive swallow evaluation one resident (R30) in a sample of 30 residents. R30 began chiking during feeding, and	F9999		

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F9999	Continued From page 42 subsequently expired the next day at the hospital In addition, the facility failed to monitor, assess and initiate emergency response services for R30) who went into respiratory arrest following the choking incident during dining. R30 was transported to the emergency room approximately 2 hours after choking incident, intubated in the emergency room and subsequently expired 30 hours later. Findings include: R30's closed record review on 10/13/11 reveals nursing notes dated 8/8/11 at 5:45pm stating R30 turned blue during evening meal, was sent to hospital and admitted with a diagnosis of respiratory failure. Previous nursing documentation dated 7/18/09 through 7/12/11 states R30 has had no problems during feeding. The Physician's Order Sheet (POS) dated 3/22/11 shows an order for swallow evaluation. There was no documentation found to support need for a swallow evaluation. Physician's Progress notes dated 2/10/10 through 7/13/11 makes no reference to any concerns with food and/or liquid ingestion. Nursing Care Plan dated 4/4/11 states R30 demonstartes some risk to potentially choke/aspirate foods or liquids due to general problems with chewing and/or swallowing. The Minimum Data Set (MDS) dated 6/17/11 states R30 requires extensive assist with meals, with one-person physical assist. Dietary notes dated 6/17/11 shows R30 on a pureed diet with honey thick liquids. Speech Therapy notes dated 3/22/11 shows R30 assessed by E20 (Speech Therapist) in response	F9999		

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F9999	Continued From page 43 to referral from nursing staff. The screen states "referral requested diet change. Pt (patient) displayed difficulty in eating and swallowing diet w/ (with) hard swallows and c/c ing (choking/coughing) at lunch." During an interview with E20 and E19 (Speech Therapist) on 10/14/11 at 2:15pm, E20 confirmed that she did assess R30 on 3/22/11. When asked if her assessment constitutes a swallow evaluation, E20 responded that the order for swallow evaluation was unclear, and that she did not know whether the ordering physician wanted an internal swallow evaluation or an external evaluation. E20 went on to say that she conducted an external evaluation which consisted of 1:1 feeding with close observation of R30. E20 stated that R30 was choking and coughing during the screen and she (E20) recommended a downgrade in food consistency from general to puree. E20 stated that in her opinoin, there was no need for further screening. E20 also stated that she did not make any recommendations for further monitoring of R30's tolarance of the new food consistency. E20 stated that if R30 was not tolerating the pureed consistency the department would have known that. According to E20, speech therapy monitors luch meals for all residents with swallowing concerns. E20 described R30 as a self-feeder and when noted to be slow in eating, would receive assist with feeding. E19 stated during this same interview that she (E19) is not familiar with R30, and went on to say that the facility's policy is to monitor residents with swallowing concern on three occasions over a two week period to see how these residents are tolerating the new food consistency. Neither E19 nor E20 knew if R30 was monitored per facility's	F9999		

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policy. Both E19 and E20 stated that the therapist who may have monitored R30 no longer works at the facility and were unable to provide documentation to support R30 being monitored.

E24, Nurse, was the nurse that took care of R30 during the choking incident. E24's documentation dated 8/8/11 at 5:45pm states R30's face turned blue and she suctioned R30 and conducted an assessment of R30's vital signs. The documentation goes on to state that she (E24) administered Oxygen by nasal cannula at a rate of 3 liters per minute and the physician was notified, who ordered that R30 be transferred to the hospital and given Tylenol for an elevated temperature. The notes state that the ambulance service was called (no time indicated). According to E24's notes, the ambulance service arrived at 6:45pm to transfer R30 to the hospital. A subsequent note at 7:30pm states ambulance service called to say R30 would be taken to the nearest hospital. At 10:00pm, E24 wrote that R30 was admitted to the hospital with a diagnosis of respiratory failure.

During an interview with E24 on 10/14/11 at 3:00pm, E24 requested E2's (Director of Nursing, DON) presence during interview. E24 stated that she was in the same dining room with R30, she heard R30 coughing, immediately told the certified nurses aid (CNA) to stop feeding R30, and immediately went over to R30, immediately supported R30's chest and patted R30 on the back. According to E24, R30 was turning blue and she (E24) began suctioning R30 with a suction that was next to R30 in the dining room. E24 stated she believed there was something in R30's airway obstructing her breathing. During

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the interview E24 could not recall how long she was suctioning R30, thinks she suctioned for more than 15 minutes, and that R30's skin color returned to normal, and with the assistance of E25 (CNA), transported R30 to her room and transferred her to bed. Once in bed, E24 assessed R30's vital signs, discovered that R30 had a temperature of 101 degrees farenheit and called then physician. E24 stated she could not recall at what time she called the ambulance service but remembers the service arrived very quickly, within 1-5 minutes. E24 stated that she did not call 911 emergency service because R30's condition had improved.
E25 (CNA) was interviewed on 10/14/11 at 4:15PM. E25 requested that E2 (DON) be present during the interview. E25 speaks very little English (Korean speaking) and E26 (Accounting Conlultant) was present as translator. E25 stated she was feeding R30 and 2 other residents when R30 began to cough, 3-4 coughs. When asked to demonstrate the type of cough, E25 demonstrating a choking cough. E25 stated she asked E24 if she should stop feeding R30 and E24 told her to stop. E25 stated the cough was different from the usual. E25 said while E24 was suctioning R30, she, E25, held R30's shoulder to maintain R30 in an upright position. E25 stated that R30 often leans to the side due to poor trunk control. E25 could not remember what R30's posture was like during feeding and coughing. E25 confirmed that she assisted E24 in transferring R30 back to bed where she (E25) remianed with R30 for 30-40 minutes until ambulance service came. E25 stated she was concerned that R30 would have choked again. E25 stated that she assist R30 with evening meal on the 3-11 shift daily and that

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F9999	Continued From page 46 R30 would cough during meals about 2-3 times each week. E25 stated when this occurs she monitors R30 to see how long cough would continue. During an interview with Z6 on 10/13/11 at 10:30am, Z6 stated that E24 requested that R30 be transported to an affliate hospital and a decision was made by the ambulance service to take R30 to the nearest hospital instead. Z6 stated that upon arrival at the facility, R30 was non-responsive. The emergency service reports states the facilty called for service at 6:42pm, one hour after R30 choked on her food. (B)	F9999		