VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

In Reply Refer To: 515/012GR

October 5, 2015

Ms. Sara Dunne, Administrator
Grand Rapids Home for Veterans
3000 Monroe Avenue NW
Grand Rapids, MI 49505

Dear Ms. Dunne:

The Battle Creek VA Medical Center (VAMC) Michigan Survey Team conducted the Annual Survey of the Grand Rapids State Home for Veterans (GRSHV) on March 24-27, 2015. During the survey, deficiencies were cited and a letter was sent to you on April 24, 2015, listing those deficiencies.

On May 28, 2015, you provided initial responses for the Corrective Action Plan (CAP) which we uploaded to the portal for review by Ascellon team members. On July 13, 2015, we notified you of the need to provide additional information. Upon receipt of your response on July 14, 2015, we submitted the revised CAP to the Ascellon team lead for review. On August 5, 2015, we again contacted you on the missing information needing to be addressed. The final version was submitted to the VA on August 7, 2015, and subsequently reviewed by Ascellon team members. After the survey team reviewed the evidence of implementation of the CAP, it is determined that your facility, Grand Rapids SHV, is in compliance with all VA nursing Home Standards and I have granted the Grand Rapids State Home for Veterans full certification for the year 2015. We regret the delay in providing this notification.

If you have any questions regarding the Grand Rapids SHV certifications or the information provided to you, please contact Lisa Martin, Wyoming Health Care Center Director at (616) 249-5374. Thank you for your continued service to our nation's Veterans.

Sincerely,

Mary Beth Skupien, PhD

MARY BETH SKUPIEN, Ph.D.
Medical Center Director

Department of Veterans Affairs Medical Center
5500 Armstrong Road
Battle Creek, MI 49037-7314

Corrective Action Plan from VA Survey of March 2015

No.	How corrective action will be accomplished for those residents found to have been affected by the deficient practice.	How facility will identify other residents having the potential to be affected by the same deficient practice.	What measures will be put in place or systematic changes made to ensure deficient practice will not recur.	How facility plans to monitor, has it been implemented, and is it effective? Must be included in QA program	Dates corrective action will be accomplished
1	n/a	n/a	Yearly review of all policies will be conducted by each dept. manager or designee	Administrator or designee will review yearly and report to QA for compliance	9-1-2015 and ongoing
10	n/a	n/a	Licensure from Health Dept. will be sought and food service dept. will receive bi-yearly inspections Kent Community Health Dept. Inspector will schedule inspections as required and Dir. of Nutrition Services will report to QA with inspection results twice a year.	Inspection reports will remain on file Dir. of Nutrition Services will report to QA with inspection results twice a year.	License received on 7-17-2015
12	n/a	n/a	Buyer developed system to monitor all contracts and their expiration dates. Work statement for request for radiology services has been submitted to the State of Michigan (SOM). Awaiting approval. Once approved, the Home must follow the SOM process for bidding out the service, evaluating the bids, and selecting a vendor. A request to fast-track the process has been made.	Buyer will present quarterly to QA all contracts that are due to expire and/or currently in the SOM purchasing process. Will address issue quarterly to QA that contracts are in place and are current. Will inform QA of any issues that have risen with current contracts and seek resolution	8-1-2015 and ongoing
20	n/a	n/a	Buyer developed system to monitor all contracts and their expiration dates. Work statement for request for	Buyer will present quarterly to QA all contracts that are due to expire and/or currently in the SOM purchasing process.	8-1-2015 and ongoing

			radiology services has been submitted to the State of Michigan (SOM). Awaiting approval. Once approved, the Home must follow the SOM process for bidding out the service, evaluating the bids, and selecting a vendor. A request to fast-track the process has been made.	Will address issue quarterly to QA that contracts are in place and are current. Will inform QA of any issues that have risen with current contracts and seek resolution	
27	GRHV will partner with BCVA on Quality Assurance & Management for improving the QA program for all disciplines. 1. DON suspended CNA and initiated investigation immediately when document presented. Investigation was completed April 2015 and it was determined that all staff will be in-serviced on proper wording, abuse and neglect, and member rights. 2. All depts. will submit annual report 3. DON has updated her QA book 4. n/a 5. n/a 6. n/a 7. n/a 8.Unit Coordinators will	QA Committee has met and will add Infection Control Committee & Wound Committee, and will include monitoring and trending of incidents of member abuse/neglect. 1. ADON will monitor all verbal and written concerns for possible abuse, neglect, exploitation, and will report to Administrator and DON immediately and assist with the investigation. 2. All depts. will submit annual report 3. DON has updated her QA book 4. n/a 5. n/a 6. n/a 7. n/a 8. Will be reviewed annually with Performance Review.	All department leaders are now included in the QA committee. Staff will learn how to do trending of incidents. DON worked with BCVA on RCA and new format used. 1. All staff have been re-inserviced on abuse and neglect, member rights, and proper documentation. Nurse managers will report all concerns to Unit Coordinators immediately for investigation. 2. Administrator will ensure all depts. have annual summary for QA 3. All depts. will receive the QA policy and instructed to keep their QA books up to date. 4.See responses in # 144, 145 5. Implementation of the EMR will result in the ability for staff to collect, monitor and trend specific data on all residents. 6. DON worked with BCVA on	All departments will submit annual reports of QA monitoring. Sentinel Events will be included in QA reporting. 1. The monthly abuse/neglect reports sent to MVAA will be included in QA monitoring and will be trended. 2. Administrator will ensure all depts. have annual summary for QA. 3. Administrator will ensure all depts. maintain QA notebooks and will be addressed yearly at the QA meeting. 4.See responses in # 144, 145 5.QA reports that will be available thru the new EMR will be evaluated by the Infection Prevention nurse and reported at the quarterly QA Meetings. Monitors will be	8-1-2015 and ongoing Investigation completed 4-2015 Inservices completed by 8-1-2015 and ongoing 2. All depts. will be informed of this requirement on 8-12-2015. 3. All depts. will be informed of this requirement on 8-12-2015. 4.See responses in # 144, 145

	complete Nursing Skills checklist annually		RCA and new format used. 7. Administrator will review the POC quarterly. 8. Nurse Educator will monitor and ensure that checklist is completed.	developed as issues are identified 6.Sentinel events will be reported at QA quarterly meetings 7. Administrator will ensure that all depts. are reporting quarterly to QA committee. 8. Nurse Educator will monitor and report to DON and Unit Coordinators they are completed.	5. All depts. will be informed of this requirement on 8-12-2015. 6. 8-12-2015 7. 8-12-2015 8. 8-5-2015 .
28	n/a	n/a	GRHV will partner with BCVA on Quality Assurance & Management for improving the QA program for all disciplines. GRHV staff will work together to develop individualized care plans using the Care Conference Schedules to ensure that all care plans are completed/updated with the MDS schedules. Administrator will review the POC quarterly.	Once training is completed, will request BCVA to attend QA meeting to ensure compliance GRHV Nurse Educator worked with staff from BCVA in July and has been presenting training to each individual Treatment Team. Expected completion of training will be August 2015. Sign-in sheets for this training will be reviewed by Nurse Educator to ensure all disciplines attended and will be presented at QA meeting.	9-1-2015 Training completed 8-1-2015 8-12-2015
45	The memo was removed from the CENA Orientation Manual immediately 3-25-2015. This document was seen only by the two instructors from J2S who provide orientation, and	n/a	Nurse Educator will review J2S Orientation Manual quarterly to ensure appropriateness of documents	Report provided to QA team yearly	8-12-2015 and ongoing

	was used as a reminder to talk about the specific problem of rinsing soiled clothing. All Nursing units have secure recycle boxes, and staff are instructed to deposit all Cheat Sheets at the end of the shift in this box. Ceramic instructor has received a formal counseling for this type of behavior. Residents have been instructed to see activity supervisors if/when situations occur	n/a Residents have been instructed to see activity supervisors if/when situations occur	The DON, Administrator, Unit Coordinators, and Unit Secretaries will continuously monitor for violations of PHI and personal information and will report all violations to the Privacy Officer immediately. The Unit Coordinators will be responsible for informing the DON &/or Administrator of any possible violations, who will ensure that the Privacy Officer is informed. Ceramic instructor has received a formal counseling for this type of behavior. Her behaviors are being documented and are being addressed thru the Civil Service and Union employee performance process.	Yearly report provided to QA by Privacy Officer of violations and outcomes. Activity Supervisor will report these employee issues to Director of Member Services and they will continue to address thru the Civil Service and Union employee performance process.	Yearly and ongoing 10-10-2014 and ongoing
49	The Mail Delivery policy has been updated to instruct staff what to do if mail is accidently opened. (attachment 1)	A list of members who desire certain types of mail be opened is used and updated routinely.	All staff who handle the mail has been inserviced on the proper procedure and a copy will remain in the mail room.	Privacy Officer will monitor and report quarterly to QA of violations and outcomes.	7-15-2015 and ongoing
66	All allegations of abuse/neglect will be investigated and reported per GRHV policy (see Attachment 2). LARA requested we report all Abuse/ Neglect allegations	ADON will monitor all verbal and written concerns for possible abuse, neglect, exploitation, and will report to Administrator and DON immediately and assist with the investigation.	All Nursing staff will be re-inserviced on member abuse & neglect and how to complete Behavior checklist. The Abuse & Neglect policy has been revised.	The monthly abuse/neglect reports sent to MVAA will be included in QA monitoring and will be trended by DON.	6-1-2015 and ongoing Inservices completed by 9-1-2015

	to the VA. The Home will provide the VA Issue Briefs or memo informing them of any potential allegations and the outcomes DON suspended CNA and initiated investigation immediately when document presented. Investigation was completed April 2015 and it was determined that staff will be in-serviced on proper wording, abuse and neglect, and member rights.	ADON will monitor all verbal and written concerns for possible abuse, neglect, exploitation, and will report to Administrator and DON immediately and assist with the investigation.	All staff will be re-inserviced on abuse and neglect, member rights, and proper documentation. Nurse managers will report all concerns to Unit Coordinators immediately for investigation.	The monthly abuse/neglect reports sent to MVAA will be included in QA monitoring and will be trended by DON.	6-1-2015 and ongoing
67	Member 2 had a dignity bag placed over his foley catheter when it was identified by the Surveyor. The information is now included on the member's Cheat Sheet.	Staff in Central Supply has been asked to stock all units with dignity bags weekly to ensure they are available. Unit nursing staff were instructed to review all residents to ensure they have dignity bags.	Nursing staff will be re-educated on the importance of member dignity.	Unit Coordinators will constantly be aware of member dignity concerns and address them immediately with the staff responsible. They will report all violations to the DON/ADON who will work with HR & the contractors as needed to educate staff & correct the concerns.	9-1-2015 and ongoing
	All early tray orders were discontinued.	All early tray orders were discontinued on all units. The Dietary Department will work with staff to place trays in the meal carts to that when they are removed, they will be served to all members at a table at the same time.	Director of Nutrition Services or designee has revised department practice to ensure early trays are not ordered with the exception of providing early meals to those who will be out of the facility for appointments or activity trips. System implemented for meal service	The Director of Nutrition Services will work with the nursing staff to make acceptable, individual arrangements for members meals. She will report any changes in regular meal service quarterly at QA meeting.	6-1-2015 and ongoing

			on units		
69	Contact information has been posted on each Nursing Unit that indicates the two recognized Ombudsman and how to contact him. Also included are contact information for other agencies to report problems and concerns. Adult Well-Being Services Ombudsman, who routinely visits the Home and speaks with members, attended the Member Council Meeting. He spoke about how to contact him and the process he follows when receiving a complaint. This was broadcast in-house and was reported in the meeting minutes (see Attachment 3)	n/a	n/a	Social Services will monitor monthly and report to QA that the information is posted on the units and that Issue Identification Forms are available.	3/27/2015, 6-1-2015 and ongoing 5-6-2015
72	Activity staff will be pulled from other areas to ensure activities continue on the Main Courtyard.	Activity staff will be pulled from other areas to ensure posted activities occur on all units.	Biweekly unit observations will occur on the Main Courtyard to ensure programming matches the calendar (see Attachment 4).	This monitor will be reported in the QA meetings.	5-15-2015 and ongoing
88	The Interdisciplinary Team has completed a change of prior assessment as a Significant Change.	All disciplines were instructed to review all MDS assessments for accuracy and to discuss all member conditions/concerns at their weekly Unit Meeting.	All current MDS Nurses have attended the training for MDS certification.	RN Manager 14's to supervise MDS Nurses and complete monthly audits. They will report audit findings to the QA Committee quarterly BCVA has agreed to assist GRHV with Root Cause	6-1-2015 2015 and ongoing 9-1-2015

				Analysis investigations and Quality Assurance to help improve monitoring and investigations.	
91	The Interdisciplinary Team has worked with BCS to complete an accurate assessment.	All disciplines have reviewed their residents to determine accuracy of assessments.	The Interdisciplinary Teams have been re-educated on referring to Behavioral Care Solutions (BCS) and follow up. Staff has been re-educated on the importance of accurate assessments documentation and follow up. A policy was developed and staff inserviced on the new system that when members are transferred from one unit to another, the Interdisciplinary Teams will contact the receiving Interdisciplinary Team members and give a report about the member and the status of his current condition, ongoing assessment, and care plan. BCS will monitor residents referred to them and will have the appropriate documentation and follow-up. BCS will monitor residents referred to them will have the appropriate documentation and follow-up.	Copy of the team conference forms are sent to the Dir. Of Social Services with each transfer. Data will be then presented at the quarterly QA meetings by the Dir. Social Services will monitor BCS referrals and report to QA quarterly. This data will be presented at the QA meetings by Social Services and BCS liaison.	8-12-2015 and ongoing 100% compliance was recorded for the month of July with all unit to unit transfers.
92	The Interdisciplinary Team has worked with BCS to complete an accurate care	Interdisciplinary Teams have reviewed their residents to determine accuracy of care	Staff have been re-educated on the policies that address significant changes, care	Nurse Educator will monitor and report quarterly to QA committee regarding	8-12- 2015 and ongoing

	plans on the identified members. A significant change assessment was completed on the identified members and the care plans were revised.	plans.	planning, and interdisciplinary team meetings. Social Services and Nursing will be re-educated on the importance of documenting identified problems on the Care Conference Sheet, on the Care Plan, and following up on all issues. The Interdisciplinary Teams will be re-educated concerning Behavioral Care Solutions (BCS) referrals and follow up. A policy was developed and staff inserviced that when members are transferred from one unit to another, the Interdisciplinary Teams will contact the receiving Interdisciplinary Team members.	inservices. Compliance regarding behavioral care planning and individualized interventions will be monitored by BCS and reported quarterly to QA. Copy of the team conference forms are sent to the Dir. Of Social Services with each transfer. Data will be then presented at the quarterly QA meetings by the Dir.	8-12- 2015 and ongoing 8-12- 2015 and ongoing
93	The Interdisciplinary Team completed an accurate assessment on identified residents and care plans have been updated on identified members	Interdisciplinary Team members have reviewed their residents to determine accuracy of care plans.	GRHV has partnered with BCVA for training on Care Planning and documentation follow up. Random monitoring will be completed by Activity Manager to ensure care plans address member preferences.	Activities Manger will report quarterly at the QA committee that care plans are individualized per documented member preferences.	Activity Manager will be informed of this requirement on 8-12-2015.
94	The member was re-evaluated by PT/OT and the Unit Physician for appropriate supportive equipment and an accurate wearing schedule that the member has agreed to. Care Plan was updated and provided to Surveyors prior	Interdisciplinary Teams have reviewed their residents to determine services are being provided as identified and ordered	The weekly Interdisciplinary Team meeting will discuss each member, new orders, changes in condition, and any Quality of Life concerns weekly.	Unit Coordinators will monitor accuracy of services and will report to DON. DON will report quarterly in QA	8-1-2015 and ongoing

	to exit on March 27, 2015. The Interdisciplinary Teams have met with BCS, PT/OT, and Unit Physicians to ensure appropriate services are being provided.	 Interdisciplinary Teams have reviewed their residents to determine services are being provided as identified and ordered	 BCS Monitor will be completed with all documentation received from BCS and will be reviewed weekly at Team meeting. Interdisciplinary Team members not in attendance will review the monitor and indicate that they have reviewed the documentation. A policy was developed and staff inserviced when members are transferred from one unit to another, the Interdisciplinary Teams will contact the receiving Interdisciplinary Team members and give a report about the member and the status of his Care Plan.	 This will be monitored by Social Services/BCS liaison and will be reported to the QA Team quarterly. Social Services/BCS liaison will monitor this and report to QA Team quarterly.	 7-1-2015 and ongoing 6-1-2015
96	n/a	n/a	GRHV Administrator and DON conferred with BCVA concerning reporting of Issue Briefs, Head's Up Notices, and Sentinel Events. Sentinel Event policy rewritten to address timelines (see attachment 5) BCVA partnered with GRHV to train staff on completing Root Cause Analyses. GRHV will report Issue Briefs within 24 hours (not excluding holidays and weekends) of the event.	DON/Administrator will report yearly to QA on timeliness of documentation	5-15-2015 and ongoing 7-9-2015
97	n/a	n/a	GRHV Administrator and DON conferred with BCVA concerning	DON/Administrator will report yearly to QA on timeliness of	5-15-2015

			reporting of Issue Briefs, Head's Up Notices, and Sentinel Events. Sentinel Event policy rewritten to address timelines (see attachment 5) BCVA partnered with GRHV to train staff on completing Root Cause Analyses. GRHV will report Issue Briefs within 24 hours (not excluding holidays and weekends) of the event.	documentation	 7-9-2015
99	The Interdisciplinary Team completed an accurate assessment and implemented appropriate treatment and services to identified resident	The Interdisciplinary staff responsible for completion of the RAI process has reviewed their residents to determine the accuracy of MDS and that appropriate treatments and services are being provided.	MDS nurses will be supervised by an RN Manager 14.	RN Managers will complete quarterly audits and report to the QA Committee quarterly.	7-1-2015 and ongoing
102	The Interdisciplinary Team completed an accurate assessment and implemented appropriate treatment and services to identified resident	Unit Nurses and staff physicians have reviewed their residents to determine accuracy of assessments and appropriate treatments and services are being provided for wound care.	Wound Committee will review wound reports monthly and address new wounds, make recommendations for treatments or changes in plan of care. Implementation of the new EMR will send alerts to dietitians and other disciplines when a new wound report is completed. Wound Care Nurse will be sent to seminar on wound care and management when identified.	Monthly reports of new wounds will be reported to the QA Committee at least quarterly. Wound committee member will report yearly of training attended.	7-1-2015 and ongoing ongoing
106	Referral to BCS was made 4-1-2015 and members behaviors are now being managed and monitored	Interdisciplinary staff have reviewed their residents to determine the need for BCS services and made referrals	BCS provides assistance with managing members' difficult behaviors, and will assist GRHV with placement when behaviors	Compliance regarding behavioral care planning and individualized interventions will be monitored by BCS and	8-12-2015 and ongoing

	appropriately.	after physician approval.	become unmanageable. Social Services Director will research other options for placement. The Interdisciplinary Teams will be re-educated concerning Behavioral Care Solutions (BCS) referrals and follow up, and Unit Coordinators will follow up with the BCS Monitor. Staff will be re-educated on the importance of referral, documentation, and follow up. A system exists by BCS that reports and monitors all residents that are referred to them.	reported quarterly to QA. BCS will provide quarterly reports to QA on member referrals, prescribed anti-psychotics, and gradual dose reductions of medications. Nurse Educator will monitor and report quarterly to QA committee regarding inservices.	8-12-2015 and ongoing 8-12-2015 and ongoing
108	Member requiring 1:1 supervision as identified had an information sheet with the reason for the 1:1, any behaviors the staff should be managing, care required for that member for each shift, and personal information that will help the CNA provide high quality care. This was presented to the Surveyors prior to exit conference on 3-27-15. Housekeeper responsible for allowing member to slip out of secured area has received discipline of unpaid suspension. House Supervisor received	Members requiring 1:1 supervision will have an information sheet with the reason for the 1:1, any behaviors the staff should be managing, care required for that member for each shift, and personal information that will help the CNA provide high quality care and to prevent falls. Housekeeping staff were reeducated about the security of the locked units and the type or residents on the units they need to be aware of.	The Falls Committee reviews all members with falls, restraints, and seat belts monthly. All staff will be re-educated about the security of the locked units, types or members there, and the importance of checking doors when exiting/entering. New Security system currently	Reports will be reviewed by the QA committee at least quarterly DON/Administrator will report quarterly to QA on elopements from all secured areas.	8-1-2015 and ongoing 6-1-2015 and ongoing

	discipline of unpaid suspension regarding issue involving resident 19.		being installed will have a bracelet alarm that will trigger and sound an alarm at all entry/exits and elevators on the secured units. GRHV Administration will report elopements from the Home to BCVA in the form of an Issue Brief within 24 hours of incident.		
118	n/a	n/a	The PPD of nursing staff have always been calculated manually daily with the current census. A weekly and monthly average are calculated and reported to administration. The initiation of an Electronic Medical Records system (EMR) will automatically track member census but the PPD of nursing will continue to be calculated manually by nursing assistant.	Director of Operations or designee will review and confirm the accuracy of the EMR tracking of members, and will report all discrepancies to the Administrator or the DON immediately. Monitor of PPD of nursing will be reported quarterly at the QA committee meeting.	8-12-2015
138	n/a	n/a	GRHV Pharmacy will print all orders with multiple doses in separate boxes on the MAR. Pharmacists identified priority order for splitting orders: 1). Insulin 2). Tablets and capsules 3). Possible additional corrections found on MAR 4). Completed Introduction of EMR and physician order entry resulting in MARs no longer part of the	Director of Pharmacy or designee will review MARs and monitor for compliance. Report quarterly at QA.	4-30- 2015 5-31- 2015 6-30- 2015 7-31- 2015 10-1-2015

			pharmacy work flow.		
141	n/a	n/a	New single-sided med carts will be ordered for the EMR system resulting in only one stock bottle on the cart. .	New med carts were ordered on 7-17-2015. Mock surveys by Unit Coordinators will check OTC med bottles for date open and only one per cart. ADON will review monthly and report any issues found to the QA committee.	8-12-2015 and ongoing
144	n/a	n/a	Infection Prevention nurse is researching computer programs specific for infection prevention in long term care. GRHV will obtain program and/or new EMR that will assist the Infection Prevention nurse with the ability to track and trend infections, community/hospital acquired infections, analyze outbreaks, and assist with response and evaluations. Until then, the Infection Prevention nurse attends daily RN meetings for tracking member illnesses, reviews 24 hr reports, and individual medical records for infections and will monitor for prevalency.	Infection Prevention Nurse/or designee will participate in QA meetings and report quarterly on findings	8-12-2015 and ongoing
145	n/a	n/a	GRHV does have a hand washing policy that was provided to Surveyors prior to exit conference. GRHV staff have been re-inserviced on hand washing policy, and must pass the hand hygiene skills checklist. Staff not passing the hand hygiene check list will be	Infection Prevention Nurse/or designee will participate in QA meetings and report quarterly on findings	7-1-2015 and ongoing

			required to view the hand hygiene computer course in Relias Learning. All Nursing Supervisors will randomly select two Nursing employees each month for the next three months and complete the hand hygiene skills checklist and provide re-education as needed for three months or until consistent hand washing is observed.	Unit Coordinators will monitor and report progress monthly. Data will be presented to QA Team quarterly	8-1-2015 and ongoing
	DOM				
227			On 3/26/15 information was posted throughout the Home on all nursing and domiciliary care units regarding the contact information of the two recognized ombudsman. One of the ombudsmen is a neutral party from the Adult Well-Being Agency, the other is an appointed Board member from the Board of Managers who have responsibility of oversight of the Home. Town Hall Meetings were held on April 13 and May 18, 2015 (See attached minutes) in order to identify and address any current concerns, problems and/or issues. All 48 members were given a notice indicating the date, time and invitation to attend. They were informed	Monitoring will occur monthly to ensure that this identified information is accurate and available for all members and/or families. This will be reported to the QA committee quarterly by the Dir. Of Social Services. . Quarterly meeting times have been selected and DOM members informed. Social Services will report yearly	3-26- 2015, 4-13- 2015 and 5-18-2015 6-1-2015 and ongoing

			that if anyone wanted the Long Term Care Ombudsman to attend the meeting that they should contact and request his presence. On April 13th all 48 members were provided a Domiciliary Care Satisfaction Survey. The data from these surveys will be used to assess the level of satisfaction and to identify concerns, problems and/or issues which require change. During the May 18th meeting the 7 issues, problems and/or concerns which had been identified during the April 13th meeting were addressed and the action taken to resolve the issues were discussed. On May 18th a vote was taken regarding the preference of choice for identifying issues and concerns. The majority of members wanted a Town Hall Meeting which could meet every three months. Future meetings have been scheduled during the week of August 17th & November 16th 2015 and February 15, 2016. Members were encouraged to continue using the Issue Identification Forms and attending the monthly Member Council meetings in order to identify their concerns, problems and/or issues. Meeting minutes will be		

			reviewed by the Dir. of Social Services and identified issues, tracking, and trending will be reported quarterly in the QA committee.		

Department of Veterans Affairs - (Standards - Nursing Home Care)

SURVEY CLASS	SURVEY YEAR	COMPLETION DATE
Annual Survey	2015	3/27/2015

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE
Grand RapidsD	3000 Monroe Ave. N.E.	Grand Rapids	MI	49505

SURVEYED BY (VHA Field Activity of Jurisdiction)

Caleb.Hart_Gra Curtis.Bruer_Gra Debra.Wilcox_Gra Eric George Lisa Martin Michelle.Crawford_GraPatricia Steward2 Patricia.Beckmann_GrSusan Honaker

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
1	§ 51.210 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical, physical, mental, and psychological well being of each resident. A. Governing body: 1. The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, and 2. The governing body or State official with oversight for the facility appoints the administrator who is: i. Licensed by the State where licensing is required; and ii. Responsible for operations and management of the facility.	(P) Provisional Mel	S/S: E Based on review, many of the policies for the management and operation of the facility were outdated. The Master Index did not accurately reflect and match the policies being maintained. Some policies were missing or not identified correctly.	<insert CAP details here>			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
2	b. Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change: 1. The State agency and individual responsible for oversight of a State home facility. 2. The State home administrator; 3. The State employee responsible for oversight of the State home facility if a contractor operates the State home.	(M) Met					
3	C 7. Annual State Fire Marshall's report. c. State official must sign four certificates	(M) Met					
4	8. Annual certification from the responsible State agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A set forth at § 51.224);	(M) Met					
5	9. Annual certification for Drug-free Workplace Act of 1988 (VA Form 10-0143 set forth at § 51.225);	(M) Met					
6	10. Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144 set forth at § 51.226);	(M) Met					
7	11. Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 27-10-0144A located at § 51.227);	(M) Met					
8	d. Percentage of Veterans. The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veterans residents must be spouses of veterans or parents all of whose children died while serving in the armed forces of the Unites States.	(M) Met	Eighty percent of residents are Veterans.				
9	e. Management Contract Facility. If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis.	(NA) Not Applicable	Facility is not operated by an contracted entity.				

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
10	f. Licensure. The facility and facility management must comply with applicable State and local licensure laws.	(P) Provisional Met	S/S: D Based on review and interview, there is a need to confirm with Kent County Health Inspectors on the requirement for inspections of the food preparation facilities given that the food is not only provided to members but able to be purchased and consumed by members' families, staff and visitors. Documentation of that determination should be kept on file.	<insert CAP details here>			
11	g. Staffing qualifications: 1. The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. 2. Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	(M) Met					
12	h. Use of Outside Resources: 1. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h) (2) of this section. 2. Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for: i. Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and ii. The timeliness of the service.	(N) Not Met	Based on record review and interviews, there is no radiology service contact or agreement on file. Inability to hold company accountable for performing services and/or meeting requirements or obligations.	<insert CAP details here>			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
13	i. Medical Director: 1. The facility management must designate a primary care physician to serve as medical director. 2. The medical director is responsible for: i. Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services; ii. Directing and coordinating medical care in the facility; iii. Helping to arrange for continuous physician coverage to handle medial emergencies; iv. Reviewing the credentialing and privileging process; v. Participating in managing the environment by reviewing and evaluating incident reports or summarizes of Incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and vi. Monitoring employees' health status and advising the administrator on employee health policies.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
14	j. Credentialing and priviteging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologist, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. 1. The facility management must uniformly apply Credentialing criteria to licensed independent practitioners applying to provide resident care or treatment under the facility's care. 2. The facility management must verify and uniformly apply the following core criteria: Current licensures; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. 3. The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credential's file must indicate that these criteria are uniformly and individually applied. 4. The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility. 5. When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. 6. The facility management systemically must asses whether individuals with clinical privileges act within the scope of privileges granted.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
15	k. Required training of nursing aides. 1. Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or a volunteer who provide such services without pay. 2. The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless: i. That individual is competent to provide nursing and nursing related services; and ii. That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State.	(M) Met					
16	3. Registry verification. Before allowing an individual to serve as a nurse aide, facility management must receive registry verification that the individual has met competency evaluation requirements unless the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. 4. Multi-State registry verification. Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual.	(M) Met					

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17	5. Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monitary compensation. The individual must complete a new training and competency evaluation program. 6. Regular in-service education. The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must; i. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; ii. Address areas of weakness as determined in nurse aide's performance reviews and may address the special needs of residents as determined by the facility staff; and iii. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	(M) Met					
18	I. Proficiency of nurse aides. The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	(M) Met					

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19	m. Level B Requirement Laboratory services. 1. The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services: i. If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services. ii. If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes and regulations. iii. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialities and subspecialities of services and meet certification standards, statutes, and regulations. iv. The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection. v. Such services must be available to the resident seven days a week, 24 hours a day. 2. The facility management must: i. Provide or obtain laboratory services only when ordered by the primary physician; ii. Promptly notify the primary physician of the findings; iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and iv. File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
20	n. Radiology and other diagnostic services. 1. The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. i. If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations. ii. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations. iii. Radiologic and other diagnostic services must be available 24 hours a day, seven days a week. 2. The facility management must: i. Provide or obtain radiology and other diagnostic services only when ordered by the primary physician; ii. Promptly notify the primary physician of the findings; iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and iv. File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.	(N) Not Met	S/S: G Based on review and interviews, the facility has not had a contract with the company for the past five years. Upon request, the company being used was able to provide documentation of board certified radiologists' licenses. The lack of contract could result in failure to have timely radiology services available 24 hours a day, seven days a week including the taking of radiology films and providing the results to the requesting provider. It was documented on the reporting of a Sentinel event occurring in February 2015 that a radiology request was submitted during the early evening hours, but the x-ray was not taken until sometime the following morning. The company failed to promptly notify the physician of a fracture likely requiring surgical intervention.	<insert CAP details here>			

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21	o. Clinical Records. 1. The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are: i. Complete; ii. Accurately documented; iii. Readily accessible; and iv. Systematically organized.	(M) Met	A new electronic medical records system is to be implemented in 2015 which will result in records being more readily accessible.				
22	2. Clinical records must be retained for: i. The period of time required by State law; or ii. Five years from the date of discharge when there is no requirement in the State law.	(M) Met					
23	3. The facility management must safeguard clinical record information against loss, destruction, or unauthorized use;	(M) Met					
24	4. The facility management must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by: i. Transfer to another health care institution; ii. Law; iii. Third party payment contract; or iv. The resident.	(M) Met					
25	5. The Clinical record must contain: i. Sufficient information to identify the residents; v. Progress notes. iv. The results of any pre-admission screening conducted by the State; and iii. The plan of care and services provided; ii. A record of the resident's assessments;	(M) Met					

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26	p. Quality assessment and assurance. 1. Facility management must maintain a quality assessment and assurance committee consisting of: i. The director of nursing services; ii. A primary physician designated by the facility; and iii. At least three other members of the facility's staff.	(M) Met					

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27	2. The quality assessment and assurance committee: i. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii. Develops and implements appropriate plans of action to correct identified quality deficiencies; and	(N) Not Met	S/S: H Through review of documents and interviews, there was a pattern of limited oversight of critical programs and aspects of patient care including, but not limited to: Infection Control, Quality Measures, Pressure Sore monitoring (Item 102), Quality of Life (Item 67), and Staff Treatment of Residents (Item 66). There was no investigation of the documented use of punishment to change residents' behavior (Item 66). All services did not have annual reports. Service quality assurance books were inconsistent. The Director of Nursing book was outdated and lacking continuity. It should be noted that the Social Work quality assurance book was well organized and comprehensive. The committee did not seem to have oversight or provide direction of the infection control program. This critical program's deficiencies and findings are documented in Items 144 and 145. There is no evidence of presentations of data trends in patient care. As such, it is difficult to identify improvements or concerns in any consistent manner. The committee did not appear to thoroughly review Sentinel Event reporting and subsequent investigations and reporting of findings. The committee did not ensure follow up of deficiencies and issues were resolved or corrected in a timely manner (Item 28) Through interviews and document review, it was discovered that RN IIIs are not required to complete	<insert CAP details here>			

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			competencies nor is there any requirement to document competencies. We are unable to determine from the Michigan Civil Service Commission that Nurse IIIs are exempt from these reviews. Recommend once confirmation from that agency is received, it should be documented and maintained by the Director of Nursing.				
28	3. Identified quality deficiencies are corrected within an established time period.	(N) Not Met	S/S: D Based on review of records and interviews, the 2014 VA Survey finding related to Care Planning was brought to the Quality Assurance Committee as noted in the corrective action plan. It was documented in the minutes that an in-service would be completed prior to the next quarterly meeting. The next quarter it was documented that the in-service had not yet happened. There was no further follow up on the finding. It was determined that no Care Planning in-service was completed and the deficiency was not corrected.	<insert CAP details here>			
29	q. Disaster and emergency preparedness. 1. The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	(M) Met	Recommend the facility develop a process for notifying Battle Creek VA Medical Center and Wyoming Health Care Center leadership in case of emergencies (fire, evacuations, elopements, etc) or items that could potentially garner negative media or congressional attention. The facility recently experienced an electrical fire. Residents were evacuated. Although no injuries, VA leadership learned of the situation on the local news.				
30	2. The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	(M) Met					

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31	r. Transfer agreement. 1. The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that: i. Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary physician; and ii. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the nursing home or the hospital, will be exchanged between the institutions. 2. The facility is considered to have a transfer agreement in effect if the facility has an agreement with a hospital sufficiently close to the facility to make transfer feasible.	(M) Met					
32	u. Intermingling. A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.	(M) Met					
33	§ 51.40 Basic per diem. (b) During Fiscal Year 2009 and during each subsequent Fiscal Year, VA will pay a facility recognized as a State home for nursing home care the lesser of the following for nursing home care provided to an eligible veteran in such facility: (1) One-half of the cost of the care for each day the veteran is in the facility; or (2) The basic per diem rate for the Fiscal Year established by VA in accordance with 38 U.S.C. 1741(c).	(M) Met					

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34	§ 51.41 Per diem for certain veterans based on service-connected disabilities. (a) VA will pay a facility recognized as a State home for nursing home care at the per diem rate determined under paragraph (b) of this section for nursing home care provided to an eligible veteran in such facility, if the veteran: (1) Is in need of nursing home care for a VA adjudicated service-connected disability, or (2) Has a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and is in need of nursing home care. (b) For purposes of paragraph (a) of this section, the rate is the lesser of the amount calculated under the paragraph (b)(1) or (b)(2) of this section. (1) For each of the 53 case-mix levels, the daily rate for each State home will be determined by multiplying the labor component by the nursing home wage index and then adding to such amount the non-labor component and an amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, and then with the modified rate multiplied by 12 and then divided by the number of days in the year. Note to paragraph(b)(1): The amount calculated under this formula reflects the applicable or prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing these rates includes CMS information that is published in theFederal Registerevery summer and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually. (2) A rate not to exceed the daily cost of care for the month in the State home facility, as determined by the Chief Consultant, Office of Geriatrics and Extended Care, following a report to the Chief Consultant, Office of Geriatrics and Extended Care under the provisions of §51.43(b)	(M) Met					

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	of this part by the director of the State home. (c) Payment under this section to a State home for nursing home care provided to a veteran constitutes payment in full to the State home by VA for such care furnished to that veteran. Also, as a condition of receiving payments under this section, the State home must agree not to accept drugs and medicines from VA on behalf of veterans provided under 38 U.S.C. 1712(d) and corresponding VA regulations (payment under this section includes payment for drugs and medicines).						

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35	(a) As a condition for receipt of per diem under this part, the State home must submit to the VA medical center of jurisdiction for each veteran completed VA Forms 10-10EZ or VA Form 10-10EZR, VA Form 10-10SH, and must be submitted at the time of admission, with any request for a change in the level of care (domiciliary, or adult day health care), and any time the contact information has changed. (b) VA pays per diem on a monthly basis. To receive payment, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-5588. This form is set forth in full at §58.11 of this chapter. (c) Per diem will be paid under §§51.40 and 51.41 for each day that the veteran is receiving care and has an overnight stay. Per diem also will be paid when there is no overnight stay if the facility has an occupancy rate of 90 percent or greater. However, these payments will be made only for the first 10 consecutive days during which the veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care. (d) Initial per diem payments will not be made until the Under Secretary for Health recognizes the State home. However, per diem payments will be made retroactively for care that was provided on and after the date of the completion of the VA survey of the facility that provided the basis for determining that the facility met the standards of this part. (e) The daily cost of care for an eligible veteran's nursing home care for purposes of § §51.40(a)(1) and 51.41(b)(2) consists of those direct and indirect costs attributable to nursing home care at the facility divided by the total number of residents at the nursing home. (f) As a condition for receiving drugs and medicines under this part, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 for each eligible veteran. The corresponding prescriptions described in §51.42 also should be submitted to the VA medical center of jurisdiction.	(M) Met					

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36	§ 51.70 Resident Rights The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights. a. Exercise of rights. 1. The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights. 3. The resident has the right to freedom from chemical or physical restraint. 4. In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. 5. In the case of a resident who has not been determined incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	(M) Met					

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37	b. Notice of rights and services. 1. The facility management 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. Such notifications must be made prior to or upon admission and periodically during the resident's stay. 2. The resident or his or her legal representative has the right: i. Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and ii. After receipt of his or her records for review, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and with 2 working days advance notice to the facility management. 3. The resident has the right to be fully informed in language that he or she can understand of his or her total health status; 4. The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (b)(7) of this section; and 5. The facility management 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 to be billed to the resident. 6. The facility management must furnish a written description of legal rights which includes: i. A description of the manner of protecting personal funds, under paragraph (c) of this section; ii. A statement that the resident may file a complaint with the State (agency) concerning resident abuse, neglect, misappropriation of	(M) Met					

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	resident property in the facility, and non-compliance with the advance directives requirements. 7. The facility management must have written policies and procedures regarding advance directives (e.g., living wills). These requirements include provisions to inform and provide written information to all 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. If an individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility management is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 8. The facility management must inform each resident of the name and way of contacting the primary physician responsible for his or her care.						

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38	9. Notification of changes: i. Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention; B. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); C. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); D. A decision to transfer or discharge the resident from the facility as specified in § 51.80(a) of this part. ii. The facility management must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is: A. A change in room or roommate assignment as specified in § 51.100 (f)(2); or B. A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. iii. The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member.	(M) Met					

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39	c. Protection of resident funds. 1. The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility. 2. Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(6) of this section.	(M) Met					
40	3. Deposit of funds. i. Funds in excess of $100. The facility management must deposit any resident's personal funds in excess of $100 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 residents funds to that account. (In pooled accounts, there must be a separate accounting for each residents share.) ii. Funds less than $100. The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.	(M) Met					
41	4. Accounting and records. The facility management 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. i. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. ii. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	(M) Met					

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42	§ 51.70 Resident rights. (C) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows.	(M) Met					
43	6. Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility.	(M) Met					
44	d. Free Choice. The resident has the right to: 1. Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and 2. Unless determined incompetent or otherwise determined to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	(M) Met					

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45	e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 1. Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. 2. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; 3. The resident's right to refuse release of personal and clinical records does not apply when: i. The resident is transferred to another health care institution; or ii. Record release is required by law.	(N) Not Met	S/S: G Based on document review and interviews. During the Survey, an email identifying a resident by name and related to fecal matter being discovered by family on the resident's clothing that was being washed, was discovered in the CENA Orientation Manual and being used to educate staff on the need to rinse garments thoroughly before placing in laundry bags. It could not be determined how many staff learned of this resident's name and issue. The email has be removed from the manual. The Privacy Officer was made aware of this issue by the Survey Team. A nursing care "cheat sheet" as defined as a document used to note resident and nursing service concerns was discovered in a public place. These forms contained identification information and potentially embarrassing personal information related to medical and social concerns. Although a new process for collecting all forms at the end of shift was implemented, the Privacy Officer was not made aware of this privacy violation and not involved in the resolution of the problem. A Ceramics instructor "teased" a resident in front of a visitor related to the resident's potential for fainting and stated they hoped the member does not "fall out." The member was embarrassed and no longer wants to participate due to this incident.	<insert CAP details here>			
46	f. Grievances. A resident has the right to: 1. Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and 2. Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	(M) Met					

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47	g. Examination of survey results. A resident has the right to: 1. Examine the results of the most recent VA survey with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and 2. Receive information from agencies acting as clinical advocates, and be afforded the opportunity to contact these agencies.	(M) Met					
48	h. Work. The resident has the right to: 1. Refuse to perform services for the facility; 2. Perform services for the facility, if he or she chooses, when: i. The facility has documented the need or desire for work in the plan of care; ii. The plan specifies the nature of the services performed and whether the services are voluntary or paid; iii. Compensation for paid services is at or above prevailing rates; and iv. The resident agrees to the work arrangement described in the plan of care.	(M) Met					
49	i. Mail. The resident has the right to privacy in written communications, including the right to: 1. Send and promptly receive mail that is unopened; and 2. Have access to stationary, postage, and writing implements at the resident's own expense.	(P) Provisional Met	S/S: D Based on document review and interview, it was reported that a letter addressed to a member was opened by someone other than the member and the word "OOPS" was written on the opened envelop and given to the member. It is unknown who opened the envelop. A list of members who desire certain types of mail be opened is used and updated routinely.	<insert CAP details here>			

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50	j. Access and visitation rights. 1. The resident has the right and the facility management must provide immediate access to any resident by the following: i. Any representative of the Under Secretary for Health; ii. Any representative of the State; iii. Physicians of the resident's choice; iv. The State long-term care ombudsman; v. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time; and vi. Others who are visiting subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time .2. The facility management must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. 3. The facility management must allow representatives of the State Ombudsman Program, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, subject to State law.	(M) Met					
51	k. Telephone. The resident has the right to reasonable access to use a telephone where calls can be made without being overheard.	(M) Met					
52	l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other resident	(M) Met					
53	m. Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	(M) Met					

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54	n. Self-Administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe.	(M) Met					
55	§ 51.80 Admission, transfer and discharge rights. a. Transfer and discharge: 1. Definition. Transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. 2. Transfer and discharge requirements. The facility management must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: i. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home; ii. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home; iii. The safety of individuals in the facility is endangered; iv. The health of individuals in the facility would otherwise be endangered; v. The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility; or vi. The nursing home ceases to operate.	(M) Met					
56	3. Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (a)(2)(vi) of this section, the primary physician must document in the resident's clinical record.	(M) Met					

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57	4. Notice before transfer. Before a facility transfers or discharges a resident, the facility must: i. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. ii. Record the reasons in the resident's clinical record; and iii. Include in the notice the items described in paragraph (a)(6) of this section.	(M) Met					
58	5. Timing of the notice. i. The notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged, except when specified in paragraph (a)(5)(ii) of this section; ii. Notice may be made as soon as practicable before transfer or discharge when: A. The safety of individuals in the facility would be endangered; B. The health of individuals in the facility would be otherwise endangered; C. The resident's health improves sufficiently so the resident no longer needs the services provided by the nursing home; D. The resident's needs cannot be met in the nursing home.	(M) Met					

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59	6. Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: i. The reason for transfer or discharge; ii. The effective date of transfer or discharge; iii. The location to which the resident is transferred or discharged; iv. A statement that the resident has the right to appeal the action to the State official designated by the State; and v. The name, address and telephone number of the State long term care ombudsman.	(M) Met					
60	7. Orientation for transfer or discharge. A facility management must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	(M) Met					

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61	b. Notice of bed-hold policy and readmission. 1. Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility management must provide written information to the resident and a family member or legal representative that specifies: i. The duration of the facility's bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; and ii. The facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section permitting a resident to return. 2. Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. 3. Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room. If the resident required the services provided by the facility.	(M) Met					
62	c. Equal access to quality care. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.	(M) Met					
63	d. Admissions policy. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract to pay the facility from the resident's income or resources.	(M) Met					

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64	§ 51.90 Resident behavior and facility practices. a. Restraints. 1. The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. i. Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. ii. Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. 2. The facility management uses a system to achieve a restraint-free environment. 3. The facility management collects data about the use of restraints. 4. When alternatives to the use of restraint are ineffective, restraint is safely and appropriately used.	(M) Met					

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65	b. Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. 1. Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. 2. Physical abuse includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment. 3. Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. 4. Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. 5. Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative.	(M) Met					

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66	c. Staff treatment of residents. The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility management must: i. Not employ individuals who: A. Have been found guilty of abusing, neglecting, or mistreating individuals by a court of law; or B. Have had a finding entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of their property; and ii. 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. 2. The facility management 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. 3. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 4. The results of all investigations must be reported to the administrator or the designated representative and to other officials in accordance with State law within 5 working days of the incident, and appropriate corrective action must be taken if the alleged violation is verified.	(P) Provisional Met	S/S - D Based on observation, interview, record review, and review of facility policy, it was determined the facility staff failed to investigate an alleged incident of punishment for one (1) of 33 sampled residents (Resident #22). Findings included: The Behavior Management: Management Untoward Behavior of a Member Policy (Review Date - October 30, 2014) includes the following: • Inappropriate or disruptive behaviors of members will be handled through an interdisciplinary approach using the principles of least restrictive interventions. • When a behavior is observed, the caregiver or nurse will pull the Behavior Monitoring/Intervention Flow Record sheet (Behavior Sheet). Start a new one each time for each behavior. In column one, check off all "Behavior/Events" and initial; In column two, check off "Factors Prior to Event" and initial; In column three, check off "Staff Interventions" and initial. • At the end of the month, the case manager will pull all of the behavior sheets (from their case load) out of the BCS book, tally up all the behaviors on a new behavior sheet and summarize the information on the monthly summary. The Abuse/Neglect – Member Policy (Review Date – April 4, 2014) policy statement is – To promptly investigate alleged abuse/neglect/exploitation and take appropriate administrative action. The policy includes the following: • Purpose Statement - To provide a process for administrative response to allegations of abuse/neglect/exploitation of members and to promote the prevention of abuse/neglect/exploitation of members. • Staff shall not humiliate, harass, or threaten any members with punishment or deprivation. • House Supervisor, Unit	<insert CAP details here>			

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			Coordinator, or Charge Nurse -- Notifies Director of Nursing (DON) immediately; Assesses member and assures appropriate care and a safe environment is provided; Collaborates with reporting employee to complete the incident report. • The DON – Immediately notifies Administrator (or designee), Human Resources (or designee), Social Worker Director (or designee) and member's family or guardian; Forwards incident report to Administrator (or designee). • Human Resources (or designee) – Provides written investigation report and recommendations to Administrator (or designee) and Director of Nursing (or designee) within five (5) working days of the incident. • The Administrator – Reviews Incident Report; Collaborates with Director of Nursing (or designee) and Human Resources (or designee) in planning investigation, reviewing report. The J2S Group (Contracted Staffing Group) Abuse and Neglect Procedure (September 19, 2011) includes: • If there is suspension or an allegation of abuse and/or neglect, J2S Group immediately suspends the staff member in question without pay pending investigation. • J2S Group receives direction from the Grand Rapids Home for Veterans (GRHV) Director of Nursing (DON) or designee. • J2S Group submits their portion of the investigation to GRHV DON or designee. Resident #22 was admitted to the facility on March 17, 2005 with diagnoses of Schizophrenia, Seizure Disorder, History of Hepatitis C and Osteoarthritis. According to the resident's Quarterly Minimum Data Set (MDS) Assessment dated March 13, 2015, Resident #22's cognitive skills were severely impaired. Resident #22 was independent with bed mobility, transfers, walking in room and in corridor and locomotion on unit and				

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			independent with set up for locomotion off unit. The resident was coded for verbal and other behavior symptoms. Resident #22's Impaired Communication Care Plan (June 14, 2014) includes the following Behavior Related Interventions: • Member is redirectable but not at all time, if he/she refuses please revisit in five (5) minutes or get Charge Nurse for direction (8-1-14). • Member is to go to Care Giver who is assigned to him/her on the shift. This Care Giver is to answer all questions and meet his/her needs. Other staff are to direct him/her to assigned Care Giver (12-3-14). • During outburst redirect in a firm voice (12-4-14). • Give snacks on time (12-4-14). Care Giver Cheat Sheets (no dates) Miscellaneous (Include Behaviors) indicate: • 11- 7 Shift – Redirect to care giver. No extras. • 7-3 and 3-11 Shifts – No interventions listed. • 3-11 Shift - Redirect to care giver. No extras. Nurses Progress Notes dated February 26, 2015 at 0700 note – On 11-7 it was reported that member was taking other's clothes. RCA caught member and made him change out of them and the clothes were returned to the rightful members. Behavior Monitoring/Intervention Flow Record February Summary documentation notes: 2/16/15 - Went to another members room to get clothes that were not his/her; Staff Intervention (Per Care Giver) – Made him/her change, take them back, lay down then take trash and PJ to Soiled Utility for punishment. In an interview on March 25, 2015 at 3:05 p.m., the Director of Nursing (DON) stated he/she was not made aware of the documentation related to Resident #22's punishment. It had not been reported and this was the first he/she had heard of it. The DON proceeded to make a telephone call				

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			instructing the care giver involved immediately be removed from the nursing unit. On March 26, 2015 at 9:05 a.m., the DON presented a March 6, 2015 Grand Rapids Home for Veterans Report Form, completed by licensed staff, indicating care giver's intervention on Resident # 22's February 26, 2015 Behavior/Intervention Flow Record is borderline abuse. Notation on the form indicates it was logged on March 15, 2015. The DON stated at this time licensed staff did report the incident of the Care Giver documenting punishment; however an investigation was not conducted.				

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67	§ 51.100 Quality of Life. A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. a. Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. b. Self-determination and participation. The resident has the right to: 1. Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans for care; 2. Interact with members of the community both inside and outside the facility; and 3. Make choices about aspects of his or her life in the facility that are significant to the resident.	(P) Provisional Met	S/S - E Based on observation and interview it was determined that care was not promoted for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect during meals. 1. Resident #2 was observed to be sitting in a wheelchair outside the dining room during the noon meal with a urine filled Foley catheter bag hanging from the wheelchair. The Foley catheter bag was not covered and in view for other residents, visitors and staff. 2. Nine (9) un-sampled residents on one unit (unit census was 29 residents) were observed to be seated in the dining room during the lunch meal service for one (1) hour and 20 minutes before being served their meal. During that time frame the nine (9) residents watched the remaining residents being served and eating their meal. The nine (9) residents voiced being frustrated and hungry while watching the other residents eat their meals. One (1) of the nine (9) residents left the dining room before being served the meal. 3. Observation of One Rankin Unit lunch meal on March 25, 2015 at 12:05 p.m. noted five (5) residents sitting and watching four (4) other residents being served and eating their meal. 4. Observation of Main Courtyard dining room on March 27, 2015 at 12:00 p.m. noted six (6) residents sitting and watching three (3) residents being served and eating their meal. Findings Included: 1. Record review of the clinical record of Resident #2 revealed the resident to have diagnoses to include: Debility, Dementia, Emphysema, Chronic Obstructive Pulmonary Disease, and Anemia. Resident #2 has severe cognition impairment and requires total care. Observation on 3/25/15 at 12:15 pm revealed the resident sitting in a	<insert CAP details here>			

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			wheelchair by the dining room where residents and staff and visitors walk past when entering the dining room. The uncovered Foley catheter bag had fallen to the floor and was lying halfway on the floor and full of urine. During an interview with the Nurse Assistant on 03/25/15 at 12:30 pm, the Nurse Assistant stated the Foley bag should always be covered and not an embarrassment concern for the resident. The Unit Nurse stated the facility would make sure all direct care staff would be responsible for making sure Foley bags were covered in public areas. 2. Meal service observations were conducted on 03/25/2015 from 11:20 a.m. to 12:58 p.m. Meal service observations on the Main Courtyard Unit revealed residents who resided on the unit were seated in the dining room at 11:20 a.m. A food cart was observed to arrive on the unit at 11:30 a.m. and staff began serving meal trays to residents seated in the dining room. Nine (9) un-sampled residents were noted to not be served their meal while the remaining residents began to eat. The nine (9) unserved residents were observed to sit at various tables in the dining room watching the other residents eat their meals, at times voicing feelings of frustration and hunger. One (1) un-sampled resident was observed to propel his/her wheelchair toward the door and the staff intervened redirecting the resident back to a table. The resident stated he/she had already ate the meal but was still hungry. Staff reminded the resident that he/she had not been served a meal and encouraged the resident to remain at the table until the meal arrived. The resident complied. A second un-sampled resident was observed to make comments regarding the long wait for a meal and exit the dining room. Staff encouraged the resident to remain in the dining room, however, the resident did not comply and				

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			continued to exit the room. A second meal cart was observed to arrive on the unit at 12:44 p.m. and staff began to serve the remaining eight (8) residents their meals at 12:50 p.m. The nine (9) un-sampled residents had waited and watched the remaining residents consume their meals for one hour and twenty minutes before being served. Interview was conducted on 03/25/2015 at 12:40 p.m. with the Unit Nurse. The Nurse stated the meal service was divided into two (2) settings to accommodate the residents who ate slower and needed more time to complete the meal. The nurse indicated being aware the residents who did not get served first would become restless while watching others eat. The nurse stated this was the facility's procedure for serving the meal each day. 3. Observation with Licensed Staff of One Rankin lunch meal on March 25, 2015 at 12:05 p.m. , noted nine (9) residents sitting in the Dining Room. Unsampled Residents # 40 and #41 were sitting at table near the right entrance door. After 20 minutes, Resident #40 received and finished lunch while Resident #41 still had not received a tray. Unsampled Residents #42, #43, and #44 were seated at a table across from Resident's # 40 and #41. Resident #42's' tray was served at 12:05 p.m. At 12:25 p.m., Residents #43 and #44 had not been served. Resident # 43 stood up and yelled "Where's my food?" Unsampled Residents #45 and #46 were seated at a table in the middle of the Dining Room. Resident #45's tray was served twenty minutes before Resident # 46. Unsampled Resident's #47 and #48 were seated at a long table in the middle of the Dining Room. Resident #47's tray was served twenty minutes before Resident # 48. In an interview on March 25, 2015 at 12:25 p.m., the Licensed Staff confirmed the observations and stated				

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			that is how it always is. The Licensed Staff stated trays are delivered to the unit by halls and not where he residents sit in the Dining Room. The Licensed Staff further stated the residents always sit in the same place in the Dining Room. 4. Observation of Main Courtyard on March 27, 2015 at 12:00 p.m. noted seven (7) residents sitting at the Dining Room center table. Two (2) of the seven (7) residents had trays and were eating their lunch meal, the other five (5) residents had not been served and were not eating. Two (2) residents were seated at a table near the television. One (1) of the two (2) residents had a tray and was eating while the other resident watched. During an interview with the resident who did not have a tray, the resident stated he/she did not mind the other resident eating, he/she was used to it. In an interview on March 27, 2015 at 12:15 p.m., the Licensed Staff confirmed the observations. The Administrator, Director of Nursing, Dietary Manager, and other Administrative Staff were informed in an exit conference on March 25, 2015, at approximately 4:30 p.m. of the concerns identified during the noon meal service regarding residents not being cared for in an environment that maintained or enhanced their dignity and respect during the meal service. Observations of the noon meal service on March 27, 2015 (two days later) revealed no changes were made to the environment and manner in which residents were served. The observations on March 27, 2015 identified residents continued to wait to eat for extended periods of time while watching other residents being served and eating their meals.				
68	c. Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.	(M) Met					

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69	d. Participation in resident and family groups. 1. A resident has the right to organize and participate in resident groups in the facility; 2. A resident's family has the right to meet in the facility with the families of other residents in the facility; 3. The facility management must provide the council and any resident or family group that exists with private space; 4. Staff or visitors may attend meetings at the group's invitation; 5. The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; 6. The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility.	(N) Not Met	S/S - F Based on observation, resident group interview, resident council minutes and staff interview, the facility failed to act upon the concerns of residents and the resident council regarding affecting resident care and life in the facility by providing access to an effective Ombudsman program. The findings include: A review of the Resident Council minutes revealed the residents repeatedly expressed concern in 2014, that they did not have an ombudsman to act as an advocate for them. According to the minutes, in June 2014, a new ombudsman was present at the meeting and introduced, however the aforementioned ombudsman did not stay long in the position. Further review of the minutes for the year 2014, revealed that residents expressed concerns regarding staffing, mail delivery, medication and security of the facility related to theft. A resident group interview was conducted on March 24th 2013 at approximately to 2:00 PM. Resident #24 was present in the meeting and posed a question regarding the course of action to take when residents had issues and didn't know who they should turn to for help. This surveyor made an inquiry regarding the current ombudsman. Several residents laughed and voiced the facility's ombudsman program was ineffective and they were receiving no feedback when they attempted to contact an ombudsman. Other residents felt as though there was no active ombudsman/advocate and there was no posting of information to identify who the current ombudsman was. Several residents added that one (1) of the people serving as an ombudsman was from the Board of Managers, which was a conflict of interest. Residents in the meeting stated this was an ongoing issue that had existed for years. Several residents expressed the resident	<insert CAP details here>			

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			council itself is a joke. Residents explained there is no accountability for the Administration and several residents are afraid to speak up for fear of retaliation. Tours of the residents' living areas on 3/25/15 at 9:45 AM confirmed that ombudsman information was not posted for residents to see. An interview was conducted on 3/24/15 at approximately 4:15 pm with the Administrator and Social Worker (SW), who confirmed the ombudsman information was not posted in the facility. The SW stated there were forms on the resident living areas where residents could communicate their issues to an ombudsman. The SW confirmed that the residents of the facility and domiciliary had pre-existing concerns regarding the ombudsman. An interview with the Nursing Supervisor on "2 Blue" on 3/25/15 at 9:59 AM revealed there were only internal complaint forms and no ombudsman forms for resident use.				
70	e. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religi	(M) Met					
71	f. Accommodation of needs. A resident has the right to: 1. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and 2. Receive notice before the resident's room or roommate in the facility is changed.	(M) Met					

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72	g. Patient activities. 1. The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	(P) Provisional Met	S/S - D Based on observation and interview it was determined facility staff failed to provide activities to meet all resident's needs on one (1) of 12 nursing units (Main Courtyard). Findings Included: Review of the Main Courtyard March 27, 2015 Activities Schedule listed 9:30 a.m. Greetings/Music, 10.00 a.m. Unit Bowling and 11:30 a.m. Daily Chronicle. Observation of Main Courtyard on March 27, 2015 at 9:35 a.m. noted five (5) residents sitting on chairs in the hallway outside of their rooms; nine (9) residents in various types of wheel chairs in the Television Room and six (6) residents in the Dining Room watching television. One (1) resident was observed sitting in his/her room with a winter coat on. The resident stated he/she had the coat on in preparation for the next smoke break because smoking was all there was to do. Additional observations on March 27, 2015 at 10:35 a.m. and 11:35 a.m. revealed the same residents sitting in the hallways, in the Television room and Dining room. There were no activities occurring on the unit as indicated on the posted activities schedule. Observation of Main Courtyard on March 27, 2015 at 12:00 p.m., noted a resident come to the Nurses Station, tap on the window and ask, "Where is Jen?" When this surveyor asked, "Who is Jen?" the resident responded "She is the activity girl and I have been looking for her because there has not been one thing going on here all day." In an interview on March 27, 2015 at 11:35 a.m., Main Courtyard Licensed Staff confirmed the units scheduled morning activities had not taken place and the unit had not received notification the activities were cancelled. During a telephone interview on March 27, 2015 at 11:37 a.m., the Activities	<insert CAP details here>			

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			Department Manager stated the Main Courtyard morning scheduled activities had not been provided because the units assigned activities staff was off and the Activity Department was short staffed. The Activities Department Manager further stated the department was in a tight pinch because of staff scheduled time off for education and vacation and three (3) scheduled bus trips for the day. The locked units were the priorities. The Activities Department Manager stated although the staff time off and bus trips were scheduled in advance, the Main Courtyard March 27, 2015 Calendar of scheduled activities had not been changed and the units assigned activities staff should have informed the units staff the activities would not take place.				
73	2. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who: - Is licensed or registered, if applicable, by the State in which practicing; and - Is certified as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body.	(M) Met					
74	h. Social Services. 1. The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well being of each resident;	(M) Met					
75	2. For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE).	(M) Met					

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76	3. Qualifications of social worker. A qualified social worker is an individual with: i. A bachelor's degree in social work from a school accredited by the Council of Social Work Education; and Note: A master's degree social worker with experience in long-term care is preferred. ii. A social work license from the State in which the State home is located, if offered by the State; and iii. A minimum of one year of supervised social work experience, in a health care setting working directly with individuals.	(M) Met					
77	4. The facility management must have sufficient support staff to meet patient's social services needs.	(M) Met					
78	5. Facilities for social services must ensure privacy for interviews.	(M) Met					
79	i. Environment. The facility management must provide: 1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;	(M) Met					
80	2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	(M) Met					
81	3. Clean bed and bath linens that are in good condition;	(M) Met					
82	4. Private closet space in each resident room, as specified in § 51.200 (d)(2)(iv) of this part;	(M) Met					
83	5. Adequate and comfortable lighting levels in all areas;	(M) Met					
84	6. Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees F.; and	(M) Met					
85	7. For the maintenance of comfortable sound levels.	(M) Met					

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86	§ 51.110 Resident assessment. The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. a. Admission orders. At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medial assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.	(M) Met					
87	b. Comprehensive assessments. (1) The facility management must make a comprehensive assessment of a resident's needs: i. Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 3.0 ---------- d. Submission of assessments. Each assessment (initial, annual, change in condition, and quarterly) using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 must be submitted electronically to VA at the IP address provided by VA to the State within 30 days after completion of the assessment document.	(M) Met					

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88	2. Frequency. Assessments must be conducted: i. No later than 14 days after the date of admission; ii. Promptly after a significant change in the resident's physical, mental, or social condition; and iii. In no case less often than once every 12 months.	(P) Provisional Met	S/S = D Based on observation, record review, interview, and review of facility policy it was determined that for one (1) of 33 sampled residents a significant change assessment was not conducted when the resident's physical status demonstrated a decline had occurred. Resident #5 sustained a left humerus fracture and following the incident experienced a significant decline in activities of daily living (ADLs), to include the ability to ambulate. A quarterly minimum data set (MDS) assessment identified a decline for the resident since the previous assessment, however, a significant change assessment was not completed with a correlated care plan review and revision to direct care for the resident based on the resident's recent decline. Findings included: Review of the Resident Assessment Policy (review date 10/29/14) revealed the purpose for the policy was to ensure a comprehensive, accurate, standardized, reproducible assessment of each member's functional capabilities and to help staff meet member needs. The policy specified a significant change in status reassessment was to be completed within seven (7) days of the Interdisciplinary Team's determination of a significant change (either improvement or decline). The policy further indicated the CAA summary would include the decisions made during the CAA process regarding whether or not to proceed to the care plan. Resident #5 was admitted to the facility on 05/20/04 with diagnoses to include Dementia, Alcoholic Brain Disorder, Psychotic Disorder, and Hypertension. The resident sustained a fall on 04/21/14 that resulted in a fractured left humerus. A significant change minimum data set (MDS) was conducted on 05/07/14. The resident was identified to be severely impaired	<insert CAP details here>			

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			in cognition. Review of the assessment revealed the resident was independent in bed mobility, and required the limited assistance of one (1) person with transfers, ambulation, toilet use, and hygiene. The resident required supervision and set up help only with dressing and extensive assistance of one (1) person with bathing. An assessment of the resident's balance during transitions and walking revealed the resident was not steady but was able to stabilize without staff assistance. A Care Area Assessment (CAA) summary associated with the assessment indicated the activities of daily living (ADL) functional/rehabilitation potential had not triggered for further review, however, due to the resident requiring limited assist with ADLs as a result of the left humerus fracture a review would be conducted. The CAA summary specified Resident #5 could not use his/her left arm for ADLs. The CAA summary does not specify that a care plan would or would not be completed related to ADL status. A quarterly MDS assessment was completed on 08/07/14 and identified the resident's cognitive status to continue to be severely impaired. The assessment identified Resident #5 to have experienced a decline in ADL status, requiring extensive assistance of one (1) person with bed mobility, transfers, ambulation, and toilet use. The resident was now totally dependent on one (1) person for dressing, personal hygiene, and bathing. Additionally, the quarterly MDS assessment identified Resident #5 to be unsteady and only be able to stabilize with staff assistance when balancing during transitions and walking. The facility was unable to provide documentation that a significant change MDS assessment was completed to reflect the resident's continued decline. Observations of Resident #5 on 03/24/15 at 9:45 a.m. and 03/25/15 at				

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			11:38 a.m. revealed the resident was seated in a wheel chair being propelled forward by a staff person during each observation. Continued observations of the resident revealed the resident did not attempt to ambulate or propel the wheel chair without staff assistance. Interview with the Unit Nurse Manager on 03/24/15 at 10:00 a.m. revealed Resident #5 had been ambulatory at the time of a fall that resulted in his arm fracture in April 2014. Since the incident the resident had slowly declined in ambulation and now required the use of a wheel chair for ambulation. Additionally, Resident #5 required more assistance with ADL performance. Interview was conducted on 03/24/15 at 3:15 p.m. with the unit Licensed Practical Nurse (LPN). The LPN stated when Resident #5 sustained a fractured left humerus in April 2014 the resident had experienced a continuous decline in status. The LPN indicated the resident had been self -ambulatory prior to the fall, however, was now wheel chair bound. Interview was conducted on 03/27/15 with the MDS Coordinator on the unit where Resident #5 resided. The Coordinator stated the 05/07/14 MDS Assessment had been completed by a previously employed nurse. The coordinator felt the difference in the documented assessment criteria could relate more to a different perception of each coordinator rather than an actual change in the resident's condition. When information obtained from staff on the unit regarding the resident's decline were presented to the Coordinator, the Coordinator stated staff had not informed him/her of the resident's declined status. The Coordinator had just assumed the resident was sustaining a gradual decline and had not recognized that a significant change assessment could be warranted. When questioned regarding training the MDS Coordinator stated he/she had trained for two (2)				

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			days at the facility prior to taking on the duties.				
89	3. Review of Assessments. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	(M) Met					
90	4. Use. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.	(M) Met					

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91	c. Accuracy of Assessments 1. Coordination. i. Each assessment must be conducted or coordinated with the appropriate participation of health professionals. ii. Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. 2. Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	(P) Provisional Met	S/S = D Based on observation, interview, record review, and review of facility policy it was determined, for one (1) of thirty 33 sampled residents, a comprehensive and accurate assessment of the resident's functional capabilities was not completed. Resident #15 experienced significant behavioral symptoms and the assessment did not include all other evaluations and assessments, including the CAA process and care planning, completed by health professionals, to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Findings included: Resident #15 was admitted to the facility's Dementia Unit on 01/14/15 with diagnoses of Vascular Dementia, Status Post Heart Transplant, End Stage Renal Disease, Hypertension, Gastro-esophageal Reflux Disease, Other Fracture (Rib Fracture) and Vitamin B Deficiency per the Admission MDS completed on 01/26/2015. A Brief Interview for Mental Status (BIMS) was completed that identified the resident's cognitive status to be scored at 8, on a scale of 1-15, reflecting moderate impairment, (scale range 8-12). The Resident Mood Interview identified a total severity score of 20 on a scale between 0 and 27 indicating severe depression. Symptoms present included feeling down, depressed or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or over eating, feeling bad about yourself- or that you are a failure or have let yourself or family down, moving or speaking so slowly that other people could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual nearly every day, thoughts that you would be better off dead, or of hurting yourself in some way with a frequency of half	<insert CAP details here>			

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			or more of the days assessed. The MDS assessment identified resident #15 had physical and verbal behavioral symptoms directed toward others occurring 1 to 3 days. The impact on others reflected the identified symptoms put others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Further behavior was the presence of rejection of care occurring 1 to 3 days. Wandering behavior was scored at 0 or not exhibited. The interview for daily preferences identified it was very important for this resident to choose what clothes to wear, take care of his personal belongings or things, choose his own bedtime, have his family or a close friend involved in discussions about his care and to have a place to lock his things to keep them safe. Activity preferences identified it was very important to have books, newspapers and magazines to read, to keep up with the news, to do things with groups of people, to do his favorite activities, and to go outside to get fresh air when the weather was good. The MDS assessment identified resident # 15's functional status as independent with activities of daily living with supervision of one person with locomotion off the unit and oversight with eating and personal hygiene. A fall with a fracture was coded prior to admission. A fall assessment, completed on 1/14/15 identified a history of falls, was oriented sometimes, had a steady gait and never had agitated behavior in the past 90 days, or since admission. Review of the Interdisciplinary Progress Record reflects resident #15 was admitted to the Dementia unit 1 Blue at 9:30 AM on 1/14/15 unaccompanied by family via transfer from an acute care facility. An entry time of 2130 states, out with daughter for supper and went to the store. Returned at 6:46 PM. At 7 PM a CNA				

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			heard resident yelling for help related to another resident who wandered into his room. Told the wandering member he "will kick his a-ss". CNA removed the other resident and a stop mesh gate was applied to his room. An entry for 1/15/15 states the resident told staff that someone stole his pants and if he found out who stole them or if he saw them on someone he would take them from him. He was angry and confused and looking for his clothes. A note of 1/16/15 states he was out with his daughter at 2 PM and came back at 5:30 PM and told staff he would rather be homeless than living here. He said the VA is going to be investigated because they are taking $7,000 a month from these guys. On 1/17/15 an entry at 8:10 AM states "this member is stating that he "popped" another member in the face twice. He was in my room by my bed, messing with my stuff". Resident had stated this to other caregivers as well. He was up at the desk requesting to speak with his daughter and left a phone message for her to "come and get me, I don't belong here". At 11:00 AM was moved to another Dementia Unit, 1 Red. At 6:00 PM came out of the dining room upset saying he "can't eat that garbage". Walked down to his room angry. Offered a sandwich and an alternative meal, which he refused, saying "I'm never going to eat here again". "It's no wonder you are under investigation when all you feed people is garbage". Up to the desk and talked with daughter on the phone, saying "I'm going to have a breakdown". "I thought it would be OK when they moved me to a different room until the food came". He called his brother saying he was going to have a breakdown and "so is Sam" (his daughter). "We need some help". On 1/18/15 an entry documents 9 bottles of medication were removed from his room. 1/20/15 an entry reflects he told staff he does not have dementia and his daughter thinks she is the				

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			guardian of him. 1/22/15 entry states, another member approached this member. He became upset and raised his fist. Members were separated. Interdisciplinary Progress Record dated 1/27/15 states Care Conference held. We discussed. Resident to be transferred to an open unit. He is doing well with directions. Dr informed. Resident states he cannot stay on a restricted unit for much longer. "I need my freedom". Message left for daughter, who is the legal guardian. 1/29/15 note says resident moved to floor, 2 South. 1/30/15 note states 3 South LPN guides member back to 2 South. He is walked back to unit by a 2 Red caregiver after he thought 2 Red was his unit. Yesterday at 6 PM he went out the South hall door setting off that alarm. He's found by security out front after he thought "it's too cold" out in front of facility. His facial expression slightly blank like. Today he states "I'm getting all screwed up now". No aggression noted yet. 2/2/15 complains about room- mate masturbating and that he has to leave. Told by RN per note that it would not be a rational decision to leave. Room change planned. He declined stating "I don't want to change rooms and do all this moving around right now". Reassured he does not have to move rooms right now. It is suggested to him to "hang out and relax" for now and perhaps he can see social worker tomorrow and go over concerns. 2/3/15 progress note says today he is claiming somebody has been in his stuff and his debit card and glasses are gone. 2/10/15 note reflects quick to anger, foul language and behaviors toward med nurse. 2/14/15 note reflects in past few days has been more confused on basic needs/ADL's. Was found in another room using the sink to wash up. States "I really do not know where I am at". 3/4/15 states he I going to leave and is not productive and wants a job. Explained staff would work on finding him some				

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			type of work. A note dated 3/20/15 states resident in dining room arguing with another resident when different resident starts coughing, he starts yelling at the member saying he cannot be around coughing since he's susceptible from his heart issues. He is given rationale for others rights by RN and stands up and starts yelling "Are you disrespecting me?!" and flips a chair over violently, then abruptly leaves. He then goes out on a trip with activities at the last minute. 3/22/15 note states member suddenly starts yelling verbally threatening toward other members driving by in their motorized chairs, accusing them of "racing around him and trying to bother him". Med nurse intervenes between member and another member. This resident motions as though he'll get up and be violent while stating "you can f-off!" He is overheard stating "I'll put tacks under their tires and give them flats". Accuses another resident of walking in on him during a shower and the RN documents the resident was simply just sitting there watching TV. RN documents, e-mail sent to 7-3 RN and Coordinator re: discussion about possible placement on MCY (Courtyard, Secure unit) due to continued threatening unprovoked aggression toward staff and other members. 3/25/15 RN progress note entered (after surveyor intervention): Late note. This member was admitted in Jan 2015 and he has had documented behavior like aggression since he came to the facility and this behavior has followed him through his transfer to 2 South Unit. The first Social Service note dated 1/28/15 states, had care conference yesterday and he is a good candidate for an open unit. Admission packet was sent in the mail to the daughter. Social services notes dated, 2/2, 2/3, 2/5, 3/4, 3/12, 3/16/, 3/20, 3/23 and 3/24/15 note his desire to leave and attempts to arrange placement elsewhere. A Social service note				

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			dated 3/25/15 (after surveyor intervention) states member continues to exhibit verbal aggressive behaviors. Chart reviewed. Address his issues with the doctor. He will be referred to BCS (Behavior Care Services, a contract service) for an evaluation. At this time there is a need for medical intervention. Member is not therapeutically engaging due to feeling he has no problems. It is documented that he became physically and verbally aggressive this weekend. Care plan reviewed. Will have to modify accordingly. 3/26/15 note message left for guardian/daughter to please contact the staff for verbal approval for psychiatric services due to behavioral problems. Will monitor. CAA Notes dated 1/20/15 notes: 2. Cognitive Loss/Dementia. The member is high functioning and it will be discussed if he could be transitioned to a less secure unit. The care plan will address monitoring for change in cognition. 7. Psychosocial Well-Being. Member struck his roommate on 1 Blue and that necessitated his transfer to 1 Red and so far there has been no serious problems. It is hoped that he can successively transition to an open unit. Care planning will address that. CAA 8. Mood State. He is in the severely depressed range. He has had previous psychiatric treatment. He is not on any psychotropic or antidepressant medications. He mentioned some feelings of wanting to die, but did not voice a suicide plan. He has a roommate who is loud, but it is not too overbearing. This social worker will be discussing a referral to BCS to evaluate him for depression. CAA 9. Behavioral Symptoms note the member has had some behavioral issues, which are showing improvement. Behavioral monitoring is being done and there will be discussion with the member's daughter/guardian regarding a BCS referral. A Care Plan dated 2/2/15 lists a				

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			problem with an onset date of 1/30/15 and states he was originally admitted to the dementia unit. He has some difficulties with his transition that has resulted in some impulse control behaviors. Due to his higher level of cognition, he has been moved to a skilled unit. Goal: will adjust to the nursing home environment. Approach: begin date 1/30/15. #1, Social worker to provide 1:1 time as needed. #2, Contact with guardian as needed. #3, Staff to encourage daily routine. Allow member to make decisions about his routine. #4 Social worker to monitor for changes with mood, behavior and cognition. Staff should inform her of any changes/concerns and do appropriate behavior documentation. #5 The member has not been referred to BCS yet due to his several changes with units. The unit social worker will refer if depressive and behavioral issues persist and if he is not responding to other treatment options. #6 Allow member to reminisce. He enjoys interactions with others. #7 Give the member praise and affirmation. #8 Encourage the member to discuss feelings, thoughts and concerns. Keep the social worker informed of serious issues to enable her to address them in an appropriate and timely manner. Handwritten entry dated 3/22: #9 During aggression remove from others to a quiet place and have member sit down, then staff can sit and have a Q & A period with rationale for consequences provided to suit member's ability to process information. Handwritten entry dated 3/24 BCS consult order, refer to disability advocates for other community placement, provide reassurance as to reduce his verbal aggression. Allow as much independence in ADL's as possible. A Care Conference Form dated 1/27/15 listed the attendance of 2 Social Workers, an RN, RD, Activity Aide and MDS Nurse. The list of 4 issues identified at the care conference was blank. The plan to				

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			address issues was also blank. A monthly summary, MDS assessment dated 1/27/15, Area cognition: short term and long term memory problems Okay. Decisions consistent/reasonable and decisions poor/requires supervision. No behaviors present. MDS Assessment Area E. Mood and Behavior: None. Problem: #1 Self-care deficit related to cognitive impairment. Goal: participate in self-care activities. Goal met. Member is up daily and dressed nicely. Will converse with other members and staff. #2 High risk for falls related to poor safety awareness secondary to cognitive deficit. (Fall risk assessment was 8 denoting low risk.) #3 Involuntary weight gain related to presence of edema. The second monthly MDS assessment summary dated 2/12/15 noted no behaviors present and under MDS Code E: Mood and Behavior: Delusions, has odd ideas about this place, physical and verbal behavioral symptoms directed toward others. CP #2 Depression related to need for placement, #4 shows little if any interest in activities. The third monthly MDS assessment summary dated 3/14/15 noted difficulty making decisions, and was otherwise the same as the previous summary. No Behavior Monitoring Forms were in the medical record nor could they be produced upon request. After surveyor intervention a behavior monitoring sheet dated 3/25/15 was presented. Under Where did this occur? Jan. Time of event: All shifts. Incomplete. A Care plan dated 3/25/15 was developed after surveyor intervention with onset date 3/25/15 vascular dementia with behavior disturbance. Goal: resident will learn to control his behaviors. Approach: same interventions with addition of refer to BCS if necessary for possible medication intervention. If medication is provided, monitor for effectiveness				

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			and side effects. Physician orders dated 3/25/15 (after surveyor intervention) reflect order entered by Physician for BCS referral re: Dementia and Aggression. Observations were completed 3/24/15 on the 2 South Unit where this resident repeatedly approached the nursing station in an agitated/aggressive state, wanting to leave the facility and insisting his daughter be called. His daughter was called from the desk and the resident spoke with her after the social worker gave him the phone. The social worker stated that would calm him down, however, after hanging up he continued to pace back and forth and loudly proclaiming his displeasure. The RN Coordinator informed the Social Worker of his behaviors to date and she said she did not know he had any of these behaviors, but, had been working on finding him placement in the community. The consent for the BSC evaluation and treatment was not obtained, but a message was left for the daughter to contact the facility. Interviews with the RN Unit Coordinator, Unit Social Worker and Director of Social Work on 3/24/15 reflected that BCS consents for evaluation and treatment are obtained on admission to the Dementia Unit with the consent for treatment and other admission paperwork. The Director of Social Work stated "we dropped the ball here; it should have been obtained in the Dementia Unit and a referral made for evaluation and treatment." The Unit Social Worker stated "I didn't know he hit someone downstairs", "Nobody told me". Interview with this resident on 3/24/15 was attempted and he replied in an agitated manner "I don't know what is going on here". Another resident, in a wheelchair, on 2 South, approached myself on 3/24/15 and whispered, "he is a TM". When asked what TM stood for he replied "Trouble Maker", then said, "he (identified resident # 15) picked up a				

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			chair and threw it at another resident in the dining room this weekend because he was coughing and yelled at him to stop coughing". "The nurse told him not to do that but he doesn't listen". "No, it didn't hit him". Interview with the DON on 3/25/15 revealed she was not familiar with this resident. Upon record review, the DON stated "he should not have been moved from the Dementia Unit". "He needed to be assessed by BCS (Behavioral Care Services) for evaluation and treatment when he was admitted to the unit with behaviors". "The physician and daughter needed to be notified and a consent obtained for BCS". "There were plenty of opportunities for the consent to be obtained from the daughter (legal guardian) and we still do not have the consent". "I am going to be reviewing this chart with the staff because this is a good example that shows these resident assessments and care plans are not accurate". "The care plans are both not developed or complete". "The care plan was not followed and we need re-education here". "No, this does not meet the professional standards of quality". "Mr ...did not receive appropriate treatment and services for his mental and psychosocial adjustment difficulty". "We need to do better". Review of Interdisciplinary Team progress notes and social service notes associated with the admission assessment revealed the significant behaviors were not noted and changes to the care plan specific to the resident's current status were not planned. A review of the facility's Resident Assessment Policy (effective 10/29/14) revealed the purpose of the policy was to provide a comprehensive, accurate, standardized, reproducible assessment of each member's functional capabilities and to help staff member needs. The comprehensive assessment will include all information				

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			specified in the State approved Resident Assessment Instrument and all other evaluations and assessments completed by health care professionals treating the member. This includes the CAA process and care planning. The assessments were neither complete nor accurate				

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92	e. Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part.	(P) Provisional Met	S/S = D Based on observation, interview, record review, and review of facility policy it was determined for two (2) of 33 sampled residents (Resident #5 and #15) a care plan was not developed based on criteria identified in a comprehensive assessment that included measurable objectives and timetables to meet each resident's needs. 1. Resident #5 experienced a significant decline in status, however, a MDS significant change in status assessment was not completed and the care plan was not revised/updated to include interventions planned that were based on the resident's declined physical status. 2. Resident #15 experienced significant behavioral symptoms and the care plan did not describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Findings Included: A review of the facility's Interdisciplinary Care Plan policy (effective 04/21/14) revealed the purpose of the policy was to ensure the provision of residents with consistent, coordinated, and comprehensive multi-disciplinary care designed to help each resident reach and maintain his/her optimal level of functioning. The policy stated a comprehensive assessment should be completed promptly after a significant change in the resident's physical or mental status and a care plan based on the assessment completed by the seventh day after the assessment. 1. Resident #5 was admitted to the facility on 05/20/04 with diagnoses to include Dementia, Alcoholic Brain Disorder, Psychotic Disorder, and Hypertension. The resident sustained a fall on 04/21/14 that resulted in a fractured left humerus. A significant change minimum data set (MDS) was conducted on 05/07/14. The resident	<insert CAP details here>			

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			was identified to be severely impaired in cognition. Review of the assessment revealed the resident was independent in bed mobility, and required the limited assistance of one (1) person with transfers, ambulation, toilet use, and hygiene. The resident required supervision and set up help only with dressing and extensive assistance of one (1) person with bathing. An assessment of the resident's balance during transitions and walking revealed the resident was not steady but was able to stabilize without staff assistance. A Care Area Assessment (CAA) summary associated with the assessment indicated the activities of daily living (ADL) functional/rehabilitation potential had not triggered for further review, however, due to the resident requiring limited assist with ADLs as a result of the left humerus fracture a review would be conducted. The CAA summary specified Resident #5 could not use his/her left arm for ADLs. The CAA summary does not specify that a care plan would or would not be completed related to ADL status. A quarterly MDS assessment was completed on 08/07/14 and identified the resident's cognitive status to continue to be severely impaired. The assessment identified Resident #5 to have experienced a decline in ADL status, requiring extensive assistance of one (1) person with bed mobility, transfers, ambulation, and toilet use. The resident was now totally dependent on one (1) person for dressing, personal hygiene, and bathing. Additionally, the quarterly MDS assessment identified Resident #5 to be unsteady and only be able to stabilize with staff assistance when balancing during transitions and walking. The facility was unable to provide documentation that a significant change MDS assessment was completed to reflect the resident's continued decline. A review of Interdisciplinary Team				

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			progress notes associated with the 08/07/14 quarterly assessment revealed the significant change/decline in status was not noted and changes to the care plan specific to the resident's current status were not planned. A review of the care plan for Resident #5 revealed a high risk for injury from falls was identified as a problem (reviewed 02/28/15). Approaches identified included monitoring the resident's location hourly and as needed; Observe the resident's gait when walking in halls and offer a chair if resident has been wandering too long. The approach of a gait belt and wheel chair during ambulation in hallway was added on 12/27/14. On 05/08/14 the approach of 1:1 supervision and use a gait belt at all times during transfers and ambulation was added to the care plan to address falls. The care plan developed to address a self-care deficit (reviewed 02/28/15) included approaches that stated the resident was independent with bed mobility and was ambulatory with a gait belt. The approaches further indicated the resident was to be provided limited assistance with personal hygiene, requiring cueing to apply lotion and perform oral hygiene. Staff were to set up items if needed and provide cueing during dressing. The care plan for an ADL deficit also included the approach of providing the resident with supervision and a gait belt when ambulating in the hallway; provide one person limited assistance with toileting and; the resident transfers independently to the bathroom. A care plan was developed to address the resident's risk for elopement due to wandering; hovering around the exit door and at times pushing the door. Approaches planned included redirecting the resident away from the exit doors to ensure safety and minimize elopement risk. The plan of care in use for Resident #5 did not reflect resident specific interventions that were planned based on the				

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			resident's current physical status. The care plan in use for Resident #5 reflected interventions that were based on the resident's assessed status on the 05/07/14 MDS assessment, before the significant decline in status had occurred. Observations of Resident #5 on 03/24/15 at 9:45 a.m. and 03/25/15 at 11:38 a.m. revealed the resident was seated in a wheel chair being propelled forward by a staff person during each observation. Continued observations of the resident revealed the resident did not attempt to ambulate or propel the wheel chair without staff assistance. Observation of the resident on 03/26/15 at 9:10 a.m. revealed the resident was seated in a wheel chair in his/her room. A CNA was with the resident. The CNA stated the resident was getting ready to lie down in bed for a nap. The CNA further indicated not being sure if the resident could ambulate but he/she had to request assistance from a second care giver with transferring the resident to the bed. Additionally, the CNA stated the resident was totally dependent on staff for daily care. Interview with the Unit Nurse Manager on 03/24/15 at 10:00 a.m. revealed Resident #5 had been ambulatory at the time of a fall resulting in the resident's arm fracture in April 2014. Since the incident the resident had slowly declined in ambulation and now required the use of a wheel chair for ambulation. Additionally, Resident #5 required more assistance with ADL performance. Interview was conducted on 03/27/15 with the MDS Coordinator on the unit where Resident #5 resided. The Coordinator stated the 05/07/14 MDS Assessment had been completed by a previously employed nurse. The Coordinator felt the difference in the documented assessment criteria could relate more to a different perception of each Coordinator rather than an actual change in the resident's condition. When information obtained from staff				

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			on the unit regarding the resident's decline were presented to the Coordinator, the Coordinator stated staff had not informed him/her of the resident's declined status. The Coordinator was unaware the plan of care was not reflective of the resident's current status. 2. Resident #15 was admitted to the facility's Dementia Unit on 01/14/15 with diagnoses of Vascular Dementia, Status Post Heart Transplant, End Stage Renal Disease, Hypertension, Gastro-esophageal Reflux Disease, Other Fracture (Rib Fracture) and Vitamin B Deficiency per the Admission MDS completed on 01/26/2015. A Brief Interview for Mental Status (BIMS) was completed that identified the resident's cognitive status to be scored at 8, on a scale of 1-15, reflecting moderate impairment, (scale range 8-12). The Resident Mood Interview identified a total severity score of 20 on a scale between 0 and 27 indicating severe depression. Symptoms present included feeling down, depressed or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or over eating, feeling bad about yourself- or that you are a failure or have let yourself or family down, moving or speaking so slowly that other people could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual nearly every day, thoughts that you would be better off dead, or of hurting yourself in some way with a frequency of half or more of the days assessed. The MDS assessment identified resident #15 had physical and verbal behavioral symptoms directed toward others occurring 1 to 3 days. The impact on others reflected the identified symptoms put others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living				

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			environment. Further behavior was the presence of rejection of care occurring 1 to 3 days. Wandering behavior was scored at 0 or not exhibited. The interview for daily preferences identified it was very important for this resident to choose what clothes to wear, take care of his personal belongings or things, choose his own bedtime, have his family or a close friend involved in discussions about his care and to have a place to lock his things to keep them safe. Activity preferences identified it was very important to have books, newspapers and magazines to read, to keep up with the news, to do things with groups of people, to do his favorite activities, and to go outside to get fresh air when the weather was good. The MDS assessment identified resident # 15's functional status as independent with activities of daily living with supervision of one person with locomotion off the unit and oversight with eating and personal hygiene. A fall with a fracture was coded prior to admission. A fall assessment, completed on 1/14/15 identified a history of falls, was oriented sometimes, had a steady gait and never had agitated behavior in the past 90 days, or since admission. Review of the Interdisciplinary Progress Record reflects resident #15 was admitted to the Dementia unit 1 Blue at 9:30 AM on 1/14/15 unaccompanied by family via transfer from an acute care facility. An entry time of 2130 states, out with daughter for supper and went to the store. Returned at 6:46 PM. At 7 PM a CNA heard resident yelling for help related to another resident who wandered into his room. Told the wandering member he "will kick his a-ss". CNA removed the other resident and a stop mesh gait was applied to his room. An entry for 1/15/15 states the resident told staff that someone stole his pants and if he found out who stole them or if he saw them on someone he would take them from him. He was angry and				

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			confused and looking for his clothes. A note of 1/16/15 states he was out with his daughter at 2 PM and came back at 5:30 PM and told staff he would rather be homeless than living here. He said the VA is going to be investigated because they are taking $7,000 a month from these guys. On 1/17/15 an entry at 8:10 AM states "this member is stating that he "popped" another member in the face twice. He was in my room by my bed, messing with my stuff". Resident had stated this to other caregivers as well. He was up at the desk requesting to speak with his daughter and left a phone message for her to "come and get me, I don't belong here". At 11:00 AM was moved to another Dementia Unit, 1 Red. At 6:00 PM came out of the dining room upset saying he "can't eat that garbage". Walked down to his room angry. Offered a sandwich and an alternative meal, which he refused, saying "I'm never going to eat here again". "it's no wonder you are under investigation when all you feed people is garbage". Up to the desk and talked with daughter on the phone, saying "I'm going to have a breakdown". "I thought it would be OK when they moved me to a different room until the food came". He called his brother saying he was going to have a breakdown and "so is Sam" (his daughter). "We need some help". On 1/18/15 an entry documents 9 bottles of medication were removed from his room. 1/20/15 an entry reflects he told staff he does not have dementia and his daughter thinks she is the guardian of him. 1/22/15 entry states, another member approached this member. He became upset and raised his fist. Members were separated. Interdisciplinary Progress Record dated 1/27/15 states Care Conference held. We discussed. Resident to be transferred to an open unit. He is doing well with directions. Dr informed. Resident states he cannot stay on a restricted unit for much				

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			longer. "I need my freedom". Message left for daughter, who is the legal guardian. 1/29/15 note says, resident moved to floor, 2 South. 1/30/15 note states 3 South LPN guides member back to 2 South. He is walked back to unit by a 2 Red caregiver after he thought 2 Red was his unit. Yesterday at 6 PM he went out the South hall door setting off that alarm. He's found by security out front after he thought "it's too cold" out in front of facility. His facial expression slightly blank like. Today he states "I'm getting all screwed up now". No aggression noted yet. 2/2/15 complains about room- mate masturbating and that he has to leave. Told by RN per note that it would not be a rational decision to leave. Room change planned. He declined stating "I don't want to change rooms and do all this moving around right now". Reassured he does not have to move rooms right now. It is suggested to him to "hang out and relax" for now and perhaps he can see social worker tomorrow and go over concerns. 2/3/15 progress note says today he is claiming somebody has been in his stuff and his debit card and glasses are gone. 2/10/15 note reflects quick to anger, foul language and behaviors toward med nurse. 2/14/15 note reflects in past few days has been more confused on basic needs/ADL's. Was found in another room using the sink to wash up. States "I really do not know where I am at". 3/4/15 states he I going to leave and is not productive and wants a job. Explained staff would work on finding him some type of work. A note dated 3/20/15 states resident in dining room arguing with another resident when different resident starts coughing, he starts yelling at the member saying he cannot be around coughing since he's susceptible from his heart issues. He is given rationale for others rights by RN and stands up and starts yelling "Are you disrespecting me?!" and flips a chair over violently, then abruptly				

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			leaves. He then goes out on a trip with activities at the last minute. 3/22/15 note states member suddenly starts yelling verbally threatening toward other members driving by in their motorized chairs, accusing them of "racing around him and trying to bother him". Med nurse intervenes between member and another member. This resident motions as though he'll get up and be violent while stating "you can f-off!" He is overheard stating "I'll put tacks under their tires and give them flats". Accuses another resident of walking in on him during a shower and the RN documents the resident was simply just sitting there watching TV. RN documents, e-mail sent to 7-3 RN and Coordinator re: discussion about possible placement on MCY (Courtyard, Secure unit) due to continued threatening unprovoked aggression toward staff and other members. 3/25/15 RN progress note entered (after surveyor intervention): Late note. This member was admitted in Jan 2015 and he has had documented behavior like aggression since he came to the facility and this behavior has followed him through his transfer to 2 South Unit. The first Social Service note dated 1/28/15 states, had care conference yesterday and he is a good candidate for an open unit. Admission packet was sent in the mail to the daughter. Social services notes dated, 2/2, 2/3, 2/5, 3/4, 3/12, 3/16/, 3/20, 3/23 and 3/24/15 note his desire to leave and attempts to arrange placement elsewhere. A Social service note dated 3/25/15 (after surveyor intervention) states member continues to exhibit verbal aggressive behaviors. Chart reviewed. Address his issues with the doctor. He will be referred to BCS (Behavior Care Services, a contract service) for an evaluation. At this time there is a need for medical intervention. Member is not therapeutically engaging due to feeling he has no problems. It is documented				

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			that he became physically and verbally aggressive this weekend. Care plan reviewed. Will have to modify accordingly. 3/26/15 note message left for guardian/daughter to please contact the staff for verbal approval for psychiatric services due to behavioral problems. Will monitor. CAA Notes dated 1/20/15 notes: 2. Cognitive Loss/Dementia. The member is high functioning and it will be discussed if he could be transitioned to a less secure unit. The care plan will address monitoring for change in cognition. 7. Psychosocial Well-Being. Member struck his roommate on 1 Blue and that necessitated his transfer to 1 Red and so far there has been no serious problems. It is hoped that he can successively transition to an open unit. Care planning will address that. CAA 8. Mood State. He is in the severely depressed range. He has had previous psychiatric treatment. He is not on any psychotropic or antidepressant medications. He mentioned some feelings of wanting to die, but did not voice a suicide plan. He has a roommate who is loud, but it is not too overbearing. This social worker will be discussing a referral to BCS to evaluate him for depression. CAA 9. Behavioral Symptoms note the member has had some behavioral issues, which are showing improvement. Behavioral monitoring is being done and there will be discussion with the member's daughter/guardian regarding a BCS referral. A Care Plan dated 2/2/15 lists a problem with an onset date of 1/30/15 and states he was originally admitted to the dementia unit. He has some difficulties with his transition that has resulted in some impulse control behaviors. Due to his higher level of cognition, he has been moved to a skilled unit. Goal: will adjust to the nursing home environment. Approach: begin date 1/30/15. #1, Social worker to provide 1:1 time as needed. #2,				

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			Contact with guardian as needed. #3, Staff to encourage daily routine. Allow member to make decisions about his routine. #4 Social worker to monitor for changes with mood, behavior and cognition. Staff should inform her of any changes/concerns and do appropriate behavior documentation. #5 The member has not been referred to BCS yet due to his several changes with units. The unit social worker will refer if depressive and behavioral issues persist and if he is not responding to other treatment options. #6 Allow member to reminisce. He enjoys interactions with others. #7 Give the member praise and affirmation. #8 Encourage the member to discuss feelings, thoughts and concerns. Keep the social worker informed of serious issues to enable her to address them in an appropriate and timely manner. Handwritten entry dated 3/22: #9 During aggression remove from others to a quiet place and have member sit down, then staff can sit and have a Q & A period with rationale for consequences provided to suit member's ability to process information. Handwritten entry dated 3/24 BCS consult order, refer to disability advocates for other community placement, provide reassurance as to reduce his verbal aggression. Allow as much independence in ADL's as possible. A Care Conference Form dated 1/27/15 listed the attendance of 2 Social Workers, an RN, RD, Activity Aide and MDS Nurse. The list of 4 issues identified at the care conference was blank. The plan to address issues was also blank. A monthly summary, MDS assessment dated 1/27/15, Area cognition: short term and long term memory problems Okay. Decisions consistent/reasonable and decisions poor/requires supervision. No behaviors present. MDS Assessment Area E. Mood and Behavior: None. Problem: #1 Self-care deficit related to cognitive impairment. Goal:				

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			participate in self-care activities. Goal met. Member is up daily and dressed nicely. Will converse with other members and staff. #2 High risk for falls related to poor safety awareness secondary to cognitive deficit. (Fall risk assessment was 8 denoting low risk.) #3 Involuntary weight gain related to presence of edema. The second monthly MDS assessment summary dated 2/12/15 noted no behaviors present and under MDS Code E: Mood and Behavior: Delusions, has odd ideas about this place, physical and verbal behavioral symptoms directed toward others. CP #2 Depression related to need for placement, #4 shows little if any interest in activities. The third monthly MDS assessment summary dated 3/14/15 noted difficulty making decisions, and was otherwise the same as the previous summary. No Behavior Monitoring Forms were in the medical record nor could they be produced upon request. After surveyor intervention a behavior monitoring sheet dated 3/25/15 was presented. Under Where did this occur? Jan. Time of event: All shifts. Incomplete. A Care plan dated 3/25/15 was developed after surveyor intervention with onset date 3/25/15 vascular dementia with behavior disturbance. Goal: resident will learn to control his behaviors. Approach: same interventions with addition of refer to BCS if necessary for possible medication intervention. If medication is provided, monitor for effectiveness and side effects. Physician orders dated 3/25/15 (after surveyor intervention) reflect order entered by Physician for BCS referral re: Dementia and Aggression. Observations were completed 3/24/15 on the 2 South Unit where this resident repeatedly approached the nursing station in an agitated/aggressive state, wanting to leave the facility and insisting his daughter be called. His				

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			daughter was called from the desk and the resident spoke with her after the social worker gave him the phone. The social worker stated that would calm him down, however, after hanging up he continued to pace back and forth and loudly proclaiming his displeasure. The RN Coordinator informed the Social Worker of his behaviors to date and she said she did not know he had any of these behaviors, but, had been working on finding him placement in the community. The consent for the BSC evaluation and treatment was not obtained, but a message was left for the daughter to contact the facility. Interviews with the RN Unit Coordinator, Unit Social Worker and Director of Social Work on 3/24/15 reflected that BCS consents for evaluation and treatment are obtained on admission to the Dementia Unit with the consent for treatment and other admission paperwork. The Director of Social Work stated "we dropped the ball here; it should have been obtained in the Dementia Unit and a referral made for evaluation and treatment." The Unit Social Worker stated "I didn't know he hit someone downstairs", "Nobody told me". Interview with this resident on 3/24/15 was attempted and he replied in an agitated manner "I don't know what is going on here". Another resident, in a wheelchair, on 2 South, approached myself on 3/24/15 and whispered, "he is a TM". When asked what TM stood for he replied "Trouble Maker", then said, "he (identified resident # 15) picked up a chair and threw it at another resident in the dining room this weekend because he was coughing and yelled at him to stop coughing". "The nurse told him not to do that but he doesn't listen". "No, it didn't hit him". Interview with the DON on 3/25/15 revealed she was not familiar with this resident. Upon record review, the DON stated "he should not have been moved from the Dementia Unit". "He				

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			needed to be assessed by BCS (Behavioral Care Services) for evaluation and treatment when he was admitted to the unit with behaviors". "The physician and daughter needed to be notified and a consent obtained for BCS". "There were plenty of opportunities for the consent to be obtained from the daughter (legal guardian) and we still do not have the consent". "I am going to be reviewing this chart with the staff because this is a good example that shows these resident assessments and care plans are not accurate". "The care plans are neither not developed nor complete". "The care plan was not followed and we need re-education here". "No, this does not meet the professional standards of quality". "Mr ...did not receive appropriate treatment and services for his mental and psychosocial difficulty". "We need to do better". Review of Interdisciplinary Team progress notes and social service notes associated with the admission assessment revealed the significant behaviors were not noted and changes to the care plan specific to the resident's current status were not planned. A review of the facility's Interdisciplinary Care Plan policy (effective 04/21/14) revealed the purpose of the policy was to provide members with consistent, coordinated, and comprehensive multi-disciplinary care designed to help each resident reach and maintain his/her optimal level of functioning. The policy stated a comprehensive care plan will be developed for each member and will include measurable objectives and timetables to meet a member's medical, nursing, mental and psychosocial and other health care needs that are identified in the comprehensive assessment. The Interdisciplinary Team is responsible for implementing and overseeing the updating of the written care plan and shall review no less than quarterly and			

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			as needed to address the current needs of each member. A care plan was not developed to address the resident behaviors.				

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93	2. A comprehensive care plan must be: i. Developed within 7 calendar days after completion of the comprehensive assessment; ii. Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and iii. Periodically reviewed and revised by a team of qualified persons after each assessment.	(P) Provisional Met	S/S - E Based on observation, interview, record review and review of facility policy, it was determined the facility staff failed to individualize and revise the care plan for three (3) of 33 sampled residents (Residents #8, #9, #10). Findings Included: Interdisciplinary Care Plan (Review Date April 21, 2014) Work guidelines indicate: • Members at the Grand Rapids Home for Veterans will receive care according to an individualized interdisciplinary care plan, based upon ongoing comprehensive assessments of each member's specific needs. • Each problem should have a statement of current status, be member specific, and identify the actual or possible cause. 1. Resident #8 was admitted to the facility on August 26, 2014 with diagnoses of Dementia, Hypertension, Type II Diabetes Mellitus, Cardiovascular Disease and Chronic Obstructive Pulmonary Disease. According to the resident's Quarterly Minimum Data Set (MDS) Assessment dated December 1, 2014, Resident #8's cognitive skills were severely impaired. Resident #8 was coded independent for bed mobility, transfers, walking, locomotion, dressing, eating and personal hygiene. Observation of Resident #8 on March 24, 2015 at 10: 15 a.m. and 2:15 p.m. noted Resident #8 sitting alone in his/her room. The resident did not verbally respond to questions. Activity Progress Notes, dated August 28, 2014, notes Resident #8 likes walking and classical music. Activity Progress Notes dated December 5, 2014, indicates Resident #8 likes computer games. Care Plan Problem: Member needs mentally stimulating recreational and social activities (Last Review January 7, 2015) includes Approaches: 1. Invite and encourage to group activities of interest and 2. Remind	<insert CAP details here>			

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			member of daily activities of interest. During an interview on March 26, 2015 at 1000, Activity Staff Member acknowledged the care plan was not individualized with Resident #8's specific interest as identified in the activity progress notes dated August 28, 2014 and December 5, 2014. 2. Resident #9 was admitted to the facility on October 16, 2013 with diagnoses of Chronic Renal Disease, Type II Diabetes Mellitus, Thyroid Nodule, Chronic Venous Insufficiency, Hypertension, Peripheral Vascular Disease, Femoral Popliteal Bypass and Benign Prostatic Hypertrophy. According to the resident's Annual Minimum Data Set (MDS) Assessment dated January 20, 2015, Resident #9's Brief Interview for Mental Status (BIMS) score was 12, indicating the resident's cognitive skills were moderately impaired. Resident #9 was coded as requiring extensive assistance of one (1) person for transfer, dressing, toilet use and personal hygiene and being at risk of developing pressure ulcers. Record review revealed the following: • Nurses Progress Notes dated March 2, 2015 at 2300 note – Caregiver reported wound on member's left lateral lower leg. Open blisters were observed. • Wound and Skin Assessment dated March 2, 2015 indicate wound Left Lower Extremity, Stage II. • Nurses Progress Notes dated March 5, 2015 at 2:00 p.m. document – Treatment change to open area left lower leg. Further record review noted the Left Lower Extremity Stage II area was not included in the Care Plan. During an interview on March 26, 2015 at 3:15 p.m., the Charge Nurse and Wound Care Nurse confirmed the Left Lower Extremity Stage II area was not included in the Care Plan. 3. Resident #10 was admitted to the facility on May 20, 2005 with diagnoses of Hypertension, Depression, Dementia,			

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			Hyperlipidemia, Organic Personality Disorder and Severe Dysphagia. According to the resident's Quarterly Minimum Data Set (MDS) Assessment dated February 19, 2015, Resident #10's cognitive skills were severely impaired. Resident #10 was coded total dependence with two (2) person physical assist for bed mobility, transfers, dressing and personal hygiene. Observation of Resident #10 on March 24, 2015 at 10: 00 a.m. and March 25, 2015 at 2:00 p.m. noted Resident #10 sitting alone in his/her room. The resident did not verbally respond to questions. February 19, 2015 Activity Quarterly Note includes – He/she does like to sit in the alcove with other members to watch the TV, he/she likes to watch sports and old movies. Independent activities include sports, daily programs and listening to music. Care Plan Problem: Due to cognitive deficits he/she attends group activities usually just to watch with little or no actual participation (Last Review February 19, 2015) includes Approaches: 1. Assist member to the activities. 2. Make point to address member by name to subtly include member into each activity. During an interview on March 26, 2015 at 1000, Activity Staff Member acknowledged the care plan was not individualized with Resident #10's specific interest as identified in the activity progress notes dated February 19, 2015.			

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94	3. The services provided or arranged by the facility must: i. Meet professional standards of quality; and ii. Be provided by qualified persons in accordance with each resident's written plan of care.	(P) Provisional Met	S/S = D Based on observation, interview, record review, and review of facility policy it was determined for two (2) of 33 sampled residents (Resident #7 and #15) planned interventions were not implemented. 1. Resident #7 had a positioning deficit that required the use of a neck collar brace and chest straps for positioning. The interventions were not being implemented for the resident. 2. Resident #15 experienced significant behavioral symptoms and the care plan intervention for the Social worker to monitor for changes with mood, behavior and cognition and to contact the guardian as needed were not implemented for the resident. Findings Included: 1. Resident #7 was admitted to the facility on 04/24/13 with diagnoses that included Parkinson's Disease, Hypertension, Psychotic Disorder with Hallucinations, and Swallowing Problems. Review of the medical record revealed a physician's order dated 11/04/14 for Occupational Therapy (OT) to treat the resident to increase seating/positioning to improve posture and safety and to improve feeding abilities. Review of Occupational Therapy (OT) summary notes revealed Resident #5 received OT services from 11/04/14 thru 12/05/14. The OT discharge summary indicated the resident had met the established goals. A recommendation was made for the resident to utilize a neck collar for 30 minutes while up in a wheel chair for positioning. A physician's order was obtained on 12/19/14 for staff to apply a neck collar for 30 minutes, once in the a.m. and again in the p.m. The use of a neck collar for positioning was not included on the resident's current care plan. Further review of the medical record revealed an OT recommendation dated 08/07/14 for Resident #5 to utilize chest straps during meal time for positioning. The	<insert CAP details here>			

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			intervention was added to the resident's care plan to address a nutritional deficit. Observations were made of Resident #7 throughout the survey dates. Observation on 03/26/15 at 9:15 a.m. revealed the resident was seated in a wheel chair located in the dining area. The resident's upper torso was bent forward and to the right with his/her head almost touching the right arm of the wheel chair. A CNA entered the dining area and asked the resident if he/she was going to wake up. The CNA walked away from the resident. When questioned by the surveyor about the resident's position the CNA stated he/she would get the resident's care giver and left the room. A second CNA entered the dining room and assisted the resident with repositioning. The CNA stated the resident would just return to the same position as he/she had difficulty sitting upward. The resident was observed again at 10:30 a.m. to continue to be up in a wheel chair in the dining room during an activity. The resident's upper torso was bent forward and to the right with his/her right arm hanging down and touching the floor. The resident's head was also bent down and to the right. The resident was not observed to be wearing a neck collar or chest straps. A CNA entered the room at 10:37 a.m. and repositioned the resident. Resident #7 was observed during the noon meal service on 03/25/15 to be seated in a wheel chair positioned at a dining room table. The resident's head and upper torso was bent forward and to the right. The resident was attempting to feed him/herself with some difficulty holding the silverware. The resident was not observed to be wearing a neck collar or chest straps. Interview was conducted on 03/26/15 at 11:00 a.m. with the CNA assigned to care for Resident #7. The CNA was aware the resident had a neck collar, indicating trying to put the collar on the resident that morning. However, the				

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			resident immediately removed it. The CNA stated the resident would refuse to wear the brace most of the time. When asked if the resident's refusal of care was reported to the charge nurse, the CNA indicated not reported the refusals. Additionally, the CNA was not aware of the length of time the resident was supposed to keep the neck brace in place. During the interview a second CNA approached and stated she/he often provided care to Resident #7. This CNA stated the resident would sometimes ask for the neck brace to be put on him/her when watching television. This CNA was aware of the 30 minute timeframe for wearing the neck brace. The CNA was also aware of the resident's care plan intervention for wearing chest straps during meal service. The CNA indicated he/she placed the straps on the resident when assigned to care for him/her and the resident seemed to tolerate the chest straps very well. Interview was conducted with the Unit Nurse Manager on 03/26/15 at 3:05 p.m. The Nurse Manager was not aware staff were not consistently implementing the use of the neck collar and chest straps at meal service. Review of the policy for Interdisciplinary Care Plan (Effective 04/21/14) revealed no procedures for ensuring the implementation of interventions planned. The policy addressed procedures for ensuring the development on an individualized care plan based on resident assessment and ensuring the care plan was updated/revised by the interdisciplinary team as indicated. 2. A review of the facility's Interdisciplinary Care Plan policy (effective 04/21/14) revealed the purpose of the policy was to provide members with consistent, coordinated, and comprehensive multi-disciplinary care designed to help each resident reach and maintain his/her optimal level of functioning. The policy stated a comprehensive care plan will be				

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			developed for each member and will include measurable objectives and timetables to meet a member's medical, nursing, mental and psychosocial and other health care needs that are identified in the comprehensive assessment. The Interdisciplinary Team is responsible for implementing and overseeing the updating of the written care plan and shall review no less than quarterly and as needed to address the current needs of each member. Resident #15 was admitted to the facility's Dementia Unit on 01/14/15 with diagnoses of Vascular Dementia, Status Post Heart Transplant, End Stage Renal Disease, Hypertension, Gastro-esophageal Reflux Disease, Other Fracture (Rib Fracture) and Vitamin B Deficiency per the Admission MDS completed on 01/26/2015. A Brief Interview for Mental Status (BIMS) was completed that identified the resident's cognitive status to be scored at 8, on a scale of 1-15, reflecting moderate impairment, (scale range 8-12). The Resident Mood Interview identified a total severity score of 20 on a scale between 0 and 27 indicating severe depression. Symptoms present included feeling down, depressed or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or over eating, feeling bad about yourself- or that you are a failure or have let yourself or family down, moving or speaking so slowly that other people could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual nearly every day, thoughts that you would be better off dead, or of hurting yourself in some way with a frequency of half or more of the days assessed. The MDS assessment identified resident #15 had physical and verbal behavioral symptoms directed toward others occurring 1 to 3 days. The impact on others reflected the				

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			identified symptoms put others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Further behavior was the presence of rejection of care occurring 1 to 3 days. Wandering behavior was scored at 0 or not exhibited. The interview for daily preferences identified it was very important for this resident to choose what clothes to wear, take care of his personal belongings or things, choose his own bedtime, have his family or a close friend involved in discussions about his care and to have a place to lock his things to keep them safe. Activity preferences identified it was very important to have books, newspapers and magazines to read, to keep up with the news, to do things with groups of people, to do his favorite activities, and to go outside to get fresh air when the weather was good. The MDS assessment identified resident # 15's functional status as independent with activities of daily living with supervision of one person with locomotion off the unit and oversight with eating and personal hygiene. A fall with a fracture was coded prior to admission. A fall assessment, completed on 1/14/15 identified a history of falls, was oriented sometimes, had a steady gait and never had agitated behavior in the past 90 days, or since admission. Review of the Interdisciplinary Progress Record reflects resident #15 was admitted to the Dementia unit 1 Blue at 9:30 AM on 1/14/15 unaccompanied by family via transfer from an acute care facility. An entry time of 2130 states, out with daughter for supper and went to the store. Returned at 6:46 PM. At 7 PM a CNA heard resident yelling for help related to another resident who wandered into his room. Told the wandering member he "will kick his a-ss". CNA removed the other resident and a stop mesh gait was applied to his room. An entry				

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			for 1/15/15 states the resident told staff that someone stole his pants and if he found out who stole them or if he saw them on someone he would take them from him. He was angry and confused and looking for his clothes. A note of 1/16/15 states he was out with his daughter at 2 PM and came back at 5:30 PM and told staff he would rather be homeless than living here. He said the VA is going to be investigated because they are taking $7,000 a month from these guys. On 1/17/15 an entry at 8:10 AM states "this member is stating that he "popped" another member in the face twice. He was in my room by my bed, messing with my stuff". Resident had stated this to other caregivers as well. He was up at the desk requesting to speak with his daughter and left a phone message for her to "come and get me, I don't belong here". At 11:00 AM was moved to another Dementia Unit, 1 Red. At 6:00 PM came out of the dining room upset saying he "can't eat that garbage". Walked down to his room angry. Offered a sandwich and an alternative meal, which he refused, saying "I'm never going to eat here again". "It's no wonder you are under investigation when all you feed people is garbage". Up to the desk and talked with daughter on the phone, saying "I'm going to have a breakdown". "I thought it would be OK when they moved me to a different room until the food came". He called his brother saying he was going to have a breakdown and "so is Sam" (his daughter). "We need some help". On 1/18/15 an entry documents 9 bottles of medication were removed from his room. 1/20/15 an entry reflects he told staff he does not have dementia and his daughter thinks she is the guardian of him. 1/22/15 entry states, another member approached this member. He became upset and raised his fist. Members were separated. Interdisciplinary Progress Record dated 1/27/15 states Care Conference				

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			held. We discussed. The resident is to be transferred to an open unit. He is doing well with directions. Dr informed. Resident states he cannot stay on a restricted unit for much longer. "I need my freedom". Message left for daughter, who is the legal guardian. 1/29/15 note says, resident moved to floor, 2 South. 1/30/15 note states 3 South LPN guides member back to 2 South. He is walked back to unit by a 2 Red caregiver after he thought 2 Red was his unit. Yesterday at 6 PM he went out the South hall door setting off that alarm. He's found by security out front after he thought "it's too cold" out in front of facility. His facial expression slightly blank like. Today he states "I'm getting all screwed up now". No aggression noted yet. 2/2/15 complains about room- mate masturbating and that he has to leave. Told by RN per note that it would not be a rational decision to leave. Room change planned. He declined stating "I don't want to change rooms and do all this moving around right now". Reassured he does not have to move rooms right now. It is suggested to him to "hang out and relax" for now and perhaps he can see social worker tomorrow and go over concerns. 2/3/15 progress note says today he is claiming somebody has been in his stuff and his debit card and glasses are gone. 2/10/15 note reflects: quick to anger, foul language and behaviors toward med nurse. 2/14/15 note reflects in past few days has been more confused on basic needs/ADL's. Was found in another room using the sink to wash up. States "I really do not know where I am at". 3/4/15 states that he I going to leave and is not productive and wants a job. Explained staff would work on finding him some type of work. A note dated 3/20/15 states resident in dining room arguing with another resident when different resident starts coughing, he starts yelling at the member saying he cannot be around			

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			coughing since he's susceptible from his heart issues. He is given rationale for others rights by RN and stands up and starts yelling "Are you disrespecting me?!" and flips a chair over violently, then abruptly leaves. He then goes out on a trip with activities at the last minute. 3/22/15 note states member suddenly starts yelling verbally threatening toward other members driving by in their motorized chairs, accusing them of "racing around him and trying to bother him". Med nurse intervenes between member and another member. This resident motions as though he'll get up and be violent while stating "you can f-off!" He is overheard stating "I'll put tacks under their tires and give them flats". Accuses another resident of walking in on him during a shower and the RN documents the resident was simply just sitting there watching TV. RN documents, e-mail sent to 7-3 RN and Coordinator re: discussion about possible placement on MCY (Courtyard, Secure unit) due to continued threatening unprovoked aggression toward staff and other members. 3/25/15 RN progress note entered (after surveyor intervention): Late note. This member was admitted in Jan 2015 and he has had documented behavior like aggression since he came to the facility and this behavior has followed him through his transfer to 2 South Unit. The first Social Service note dated 1/28/15 states, had care conference yesterday and he is a good candidate for an open unit. Admission packet was sent in the mail to the daughter. Social services notes dated, 2/2, 2/3, 2/5, 3/4, 3/12, 3/16/, 3/20, 3/23 and 3/24/15 note his desire to leave and attempts to arrange placement elsewhere. A Social service note dated 3/25/15 (after surveyor intervention) states member continues to exhibit verbal aggressive behaviors. Chart reviewed. Address his issues with the doctor. He will be referred to BCS (Behavior Care Services, a				

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			contract service) for an evaluation. At this time there is a need for medical intervention. Member is not therapeutically engaging due to feeling he has no problems. It is documented that he became physically and verbally aggressive this weekend. Care plan reviewed. Will have to modify accordingly. 3/26/15 note message left for guardian/daughter to please contact the staff for verbal approval for psychiatric services due to behavioral problems. Will monitor. CAA Notes dated 1/20/15 notes: 2. Cognitive Loss/Dementia. The member is high functioning and it will be discussed if he could be transitioned to a less secure unit. The care plan will address monitoring for change in cognition. 7. Psychosocial Well-Being. Member struck his roommate on 1 Blue and that necessitated his transfer to 1 Red and so far there have been no serious problems. It is hoped that he can successively transition to an open unit. Care planning will address that. CAA 8. Mood State. He is in the severely depressed range. He has had previous psychiatric treatment. He is not on any psychotropic or antidepressant medications. He mentioned some feelings of wanting to die, but did not voice a suicide plan. He has a roommate who is loud, but it is not too overbearing. This social worker will be discussing a referral to BCS to evaluate him for depression. CAA 9. Behavioral Symptoms note the member has had some behavioral issues, which are showing improvement. Behavioral monitoring is being done and there will be discussion with the member's daughter/guardian regarding a BCS referral. A Care Plan dated 2/2/15 lists a problem with an onset date of 1/30/15 and states he was originally admitted to the dementia unit. He has some difficulties with his transition that has resulted in some impulse control behaviors. Due to his higher level of				

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			cognition, he has been moved to a skilled unit. Goal: will adjust to the nursing home environment. Approach: begin date 1/30/15. #1, Social worker to provide 1:1 time as needed. #2, Contact with guardian as needed. #3, Staff to encourage daily routine. Allow member to make decisions about his routine. #4, Social worker to monitor for changes with mood, behavior and cognition. Staff should inform her of any changes/concerns and do appropriate behavior documentation. #5 the member has not been referred to BCS yet due to his several changes with units. The unit social worker will refer if depressive and behavioral issues persist and if he is not responding to other treatment options. #6 Allow member to reminisce. He enjoys interactions with others. #7 give the member praise and affirmation. #8 encourage the member to discuss feelings, thoughts and concerns. Keep the social worker informed of serious issues to enable her to address them in an appropriate and timely manner. Handwritten entry dated 3/22: #9 during aggression remove from others to a quiet place and have member sit down, then staff can sit and have a Q & A period with rationale for consequences provided to suit member's ability to process information. Handwritten entry dated 3/24 BCS consult order, refer to disability advocates for other community placement, provide reassurance as to reduce his verbal aggression. Allow as much independence in ADL's as possible. A Care Conference Form dated 1/27/15 listed the attendance of 2 Social Workers, an RN, RD, Activity Aide and MDS Nurse. The list of 4 issues identified at the care conference was blank. The plan to address issues was also blank. A monthly summary, MDS assessment dated 1/27/15, Area cognition: short term and long term memory problems Okay. Decisions consistent/reasonable and decisions				

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			poor/requires supervision. No behaviors present. MDS Assessment Area E. Mood and Behavior: None. Problem: #1 Self-care deficit related to cognitive impairment. Goal: participate in self-care activities. Goal met. Member is up daily and dressed nicely. Will converse with other members and staff. #2 High risk for falls related to poor safety awareness secondary to cognitive deficit. (Fall risk assessment was 8 denoting low risk.) #3 Involuntary weight gain related to presence of edema. The second monthly MDS assessment summary dated 2/12/15 noted no behaviors present and under MDS Code E: Mood and Behavior: Delusions, has odd ideas about this place, physical and verbal behavioral symptoms directed toward others. CP #2 Depression related to need for placement, #4 shows little if any interest in activities. The third monthly MDS assessment summary dated 3/14/15 noted difficulty making decisions, and was otherwise the same as the previous summary. No Behavior Monitoring Forms were in the medical record nor could they be produced upon request. After surveyor intervention a behavior monitoring sheet dated 3/25/15 was presented. Under Where did this occur? Jan. Time of event: All shifts. Incomplete. A Care plan dated 3/25/15 was developed after surveyor intervention with onset date 3/25/15 vascular dementia with behavior disturbance. Goal: resident will learn to control his behaviors. Approach: same interventions with addition of refer to BCS if necessary for possible medication intervention. If medication is provided, monitor for effectiveness and side effects. Physician orders dated 3/25/15 (after surveyor intervention) reflect order entered by Physician for BCS referral re: Dementia and Aggression. Observations were completed 3/24/15			

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			on the 2 South Unit where this resident repeatedly approached the nursing station in an agitated/aggressive state, wanting to leave the facility and insisting his daughter be called. His daughter was called from the desk and the resident spoke with her after the social worker gave him the phone. The social worker stated that would calm him down, however, after hanging up he continued to pace back and forth and loudly proclaiming his displeasure. The RN Coordinator informed the Social Worker of his behaviors to date and she said she did not know he had any of these behaviors, but, had been working on finding him placement in the community. The consent for the BSC evaluation and treatment was not obtained, but a message was left for the daughter to contact the facility. Interviews with the RN Unit Coordinator, Unit Social Worker and Director of Social Work on 3/24/15 reflected that BCS consents for evaluation and treatment are obtained on admission to the Dementia Unit with the consent for treatment and other admission paperwork. The Director of Social Work stated "we dropped the ball here; it should have been obtained in the Dementia Unit and a referral made for evaluation and treatment." The Unit Social Worker stated "I didn't know he hit someone downstairs", "Nobody told me". Interview with this resident on 3/24/15 was attempted and he replied in an agitated manner "I don't know what is going on here". Another resident, in a wheelchair, on 2 South, approached myself on 3/24/15 and whispered, "he is a TM". When asked what TM stood for he replied "Trouble Maker", then said, "he (identified resident # 15) picked up a chair and threw it at another resident in the dining room this weekend because he was coughing and yelled at him to stop coughing". "The nurse told him not to do that but he doesn't listen". "No, it didn't hit him".				

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			Interview with the DON on 3/25/15 revealed she was not familiar with this resident. Upon record review, the DON stated "he should not have been moved from the Dementia Unit". "He needed to be assessed by BCS (Behavioral Care Services) for evaluation and treatment when he was admitted to the unit with behaviors". "The physician and daughter needed to be notified and a consent obtained for BCS". "There were plenty of opportunities for the consent to be obtained from the daughter (legal guardian) and we still do not have the consent". "I am going to be reviewing this chart with the staff because this is a good example that shows these resident assessments and care plans are not accurate". "The care plans are both not developed or complete". "The care plan was not followed and we need re-education here". "No, this does not meet the professional standards of quality". "Mr ...did not receive appropriate treatment and services for his mental and psychosocial adjustment difficulty". "We need to do better". Review of Interdisciplinary Team progress notes and social service notes associated with the admission assessment revealed the significant behaviors were not noted and changes to the care plan specific to the resident's current status were not planned. A review of the facility's Interdisciplinary Care Plan policy (effective 04/21/14) revealed the purpose of the policy was to provide members with consistent, coordinated, and comprehensive multi-disciplinary care designed to help each resident reach and maintain his/her optimal level of functioning. The policy stated a comprehensive care plan will be developed for each member and will include measurable objectives and timetables to meet a member's medical, nursing, mental and psychosocial and other health care needs that are identified in the			

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			comprehensive assessment. The Interdisciplinary Team is responsible for implementing and overseeing the updating of the written care plan and shall review no less than quarterly and as needed to address the current needs of each member. Resident #15 experienced significant behavioral symptoms and the care plan intervention for the Social worker to monitor for changes with mood, behavior and cognition and to contact the guardian as needed were not implemented for the resident.				
95	f. Discharge summary. Prior to discharging a resident, the facility management must prepare a discharge summary that includes— (1) A recapitulation of the resident's stay; (2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	(M) Met					

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96	§ 51.120 Quality of care. Each resident must receive and the facility management 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. a. Reporting of Sentinel Events: 1. Definition. A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function. 2. Examples of sentinel events are as follows: i. Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or ii. Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or iii. Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or iv. Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or v. Assault, homicide or other crime resulting in patient death or major permanent loss of function; or vi. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall. 3. The facility management must report sentinel events to the director of the VA medical center of jurisdiction within 24 hours of identification.	(P) Provisional Met	S/S: E Based on record review, four Sentinel Events occurred since that last inspection was completed on 3/7/14. Three of the events were not reported in a timely manner. On 3/22/14, a resident was found on floor near bed and expired on 3/23/14 from craniocerebral trauma. This event was not reported until 3/28/14. On 5/4/14, a resident ran into a door while seated on a motorized scooter. Resident fell off scooter and suffered a fractured hip which resulted in surgical intervention. Resident's condition rapidly declined and he died 5/20/14. The event was reported on 5/22/14. On 2/18/15, a resident was discovered to be coughing and in distress by a housekeeper. Shortly thereafter, the resident was found face down in the hallway and not breathing. In spite of medical intervention including CPR by first responders, the Veteran died. The initial report was not sent to VA officials within the required 24 hours. On 2/24/15, the resident experienced a fall from a wheelchair and sustained a fracture requiring surgical intervention. The x-ray was not taken until the morning of 2/25. Subsequently, the resident was transferred to a local hospital on 2/25. On 2/26, State Home nursing staff contacted the hospital and learned that he experienced respiratory failure, was placed on a venti-mask, no surgical intervention was planned, and family was considering hospice care. On 3/2/15 staff learned that there could be permanent loss of function. The resident died on 3/2/15. During subsequent Root Cause Analysis, it was noted that in spite of having a care plan that indicated a tab alarm as the resident was identified at risk for falls, the resident did not have a tab	<insert CAP details here>			

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			alarm and there was no documentation to reflect why it was not in place. No seatbelt was in use in spite of cognitive impairment,				
97	4. The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. i. Goal. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.	(P) Provisional Met	S/S: E Based on record review and interviews, there were three RCAs completed although all were not within the required time frames. Sentinel Event that occurred on 3/22/14 and reported on 3/28/14: RCA report completed on 4/11/14. Sentinel Event that occurred on 5/4/14 with subsequent death on 5/20 and reported on 5/22/14. RCA report complete on 6/4/14. Sentinel Event that occurred on 2/23/15, During the review of a sentinel event related to the fall by a member who was identified as at risk for falls, it appeared that basic questions related to what, if any, precautions were taken for this member were not included in the initial report. After discussion between the WHCC Director and State Home Administrator, additional information was provided. Limited discussion was noted as related to why fall precautions were not in place while anecdotal information unrelated to event was included in the revised follow up report by State Home officials.There is no date on the follow up report but was available prior to survey. The VA is available to provide training on the use of Root Cause Analysis tools and methodologies to improve the process and documentation.	<insert CAP details here>			

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98	b. Activities of daily living. Based on the comprehensive assessment of a resident, the facility management must ensure that: i. Bathe, dress, and groom; 1. A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to: ii. Transfer and ambulate; iii. Toilet; iv. Eat; and v. Talk or otherwise communicate.	(M) Met					

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99	2. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and	(P) Provisional Met	S/S = D Based on observation, interview, and record review it was determined that appropriate treatment and services were not provided for one (1) of 33 sampled residents to maintain or improve the resident's abilities in Activities of Daily Living (ADL) functional status. Resident #5 experienced a decline in activities of daily living, to include the ability to ambulate. A comprehensive assessment of the resident's declined status was not conducted and a plan of care not developed to address the resident's declined functional status. Findings Included: Resident #5 was admitted to the facility on 05/20/04 with diagnoses to include Dementia, Alcoholic Brain Disorder, Psychotic Disorder, and Hypertension. The resident sustained a fall on 04/21/14 which resulted in a fractured left humerus. A quarterly MDS assessment was completed on 08/07/14 identified the resident's cognitive status to be severely impaired. The assessment identified resident #5 to require extensive assistance of one person with bed mobility, transfers, ambulation, and toilet use. The resident was now totally dependent on one (1) person for dressing, personal hygiene, and bathing. Additionally, the quarterly MDS assessment identified Resident #5 to be unsteady and only be able to stabilize with staff assistance when balancing during transitions and walking. Quarterly MDS assessments completed on 11/07/14 and 02/07/15 reflected the resident's status continued to be the same as the 08/07/14 quarterly MDS assessment. Each of the quarterly MDS assessments reflected a significant decline in status since the previous assessment of 05/07/14. A review of the care plan for Resident #5 revealed the facility continued to plan interventions for the resident that were based on the resident's physical status prior to the decline. For	<insert CAP details here>			

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			example, the care plan to address a potential for falls (reviewed 02/28/15) included approaches specific to the resident ambulating independently throughout the unit. The care plan developed to address a self-care deficit (reviewed 02/28/15) included approaches that stated the resident was independent with bed mobility and was ambulatory with a gait belt. The approaches further indicated the resident was to be provided limited assistance with personal hygiene, requiring cueing to apply lotion and perform oral hygiene. Staff were to set up items if needed and provide cueing during dressing. The care plan for an ADL deficit also included the approach of providing the resident with supervision and a gait belt when ambulating in the hallway; provide one person limited assistance with toileting and; the resident transfers independently to the bathroom. The plan of care addressing the resident's ADL functional status did not include interventions aimed toward maintaining or improving the resident's abilities in ambulation or personal care skills. Observations of Resident #5 on 03/24/15 at 9:45 a.m. and 03/25/15 at 11:38 a.m. revealed the resident was seated in a wheel chair being propelled forward by a staff person during each observation. The wheel chair was observed to have foot rests in place for the resident. Continued observations of the resident revealed the resident did not attempt to ambulate or propel the wheel chair without staff assistance. Observation of the resident on 03/26/15 at 9:10 a.m. revealed the resident was seated in a wheel chair in his/her room. A CNA was with the resident. The CNA stated the resident was getting ready to lie down in bed for a nap. The CNA further indicated not being sure if the resident could ambulate but he/she had to request assistance from a second care giver with transferring the resident to the bed. Additionally, the CNA stated the resident was totally				

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			dependent on staff for daily care. Interview with the Unit Nurse Manager on 03/24/15 at 10:00 a.m. revealed Resident #5 had been ambulatory at the time of a fall that broke his arm in April 2014. Since the incident the resident had slowly declined in ambulation and now required the use of a wheel chair for ambulation. The Nurse Manager stated that sometime after the resident quit ambulating he/she continued to have the ability to self-propel a wheel chair with his/her feet. The Nurse Manager had noticed that staff were now placing foot rests on the resident's wheel chair which would prevent the ability to self-propel the wheel chair for the resident. Additionally, Resident #5 required more assistance with ADL performance. Continued interview with the Unit Nurse Manager on 03/26/15 at 9:50 a.m. revealed although Resident #5 had experienced a decline in the ability to ambulate a recommendation for referral to Physical Therapy (PT) had not been made. According to the Nurse the lack of a recommendation for a PT referral was due to the resident's resistance to PT in the past. A review of MDS assessments and the current plan of care revealed no evidence of the resident's resistance to services, to include PT. Interview was conducted on 03/24/15 at 3:15 p.m. with the unit Licensed Practical Nurse (LPN). The LPN stated when Resident #5 sustained a fractured left humerus in April 2014 the resident had experienced a continuous decline in status. The LPN indicated the resident had been self -ambulatory prior to the fall, however, was now wheel chair bound. The resident also required total assistance from staff with ADL care.				
100	3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.	(M) Met					

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101	c. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	(M) Met					

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102	d. Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	(P) Provisional Met	S/S - D Based on observation, interviews, ,record review, and review of facility policy it was determined the facility staff failed to provide continued assessment and services for one (1) of 33 sampled residents (Resident #9) with a facility acquired pressure area. Findings Included: Skin Care, Wound Prevention and Wound Management Policy (Review Date February 27, 2013) includes: • Nursing staff will maintain the present state of skin integrity in Grand Rapids Home for Veterans Members through admission and continued assessments and will provide appropriate nursing interventions based on continuous assessment data. • Licensed nurses will document wound status weekly and PRN with significant changes on the Wound and Skin Assessment. • Caregivers will do a visual/head to toe skin assessment with weekly bath and PRN. Caregivers will report any unusual findings to charge nurse/supervisor. • Off load area with premium Posey boots; pillow, etc., that is appropriate to member. • Nutritional consult shall be initiated or indicated for nutritional services. Resident #9 was admitted to the facility on October 16, 2013 with diagnoses of Chronic Renal Disease, Type II Diabetes Mellitus, Thyroid Nodule, Chronic Venous Insufficiency, Hypertension, Peripheral Vascular Disease, Femoral Popliteal Bypass and Benign Prostatic Hypertrophy. According to the resident's Annual Minimum Data Set (MDS) Assessment dated January 20, 2015, Resident #9's Brief Interview for Mental Status (BIMS) score was 12, indicating the resident's cognitive skills were moderately impaired. Resident #9 was coded as requiring extensive assistance of one (1) person for transfer, dressing, toilet use and	<insert CAP details here>			4/24/2015

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			personal hygiene and being at risk of developing pressure ulcers. Record review revealed the following: • Nurses Progress Notes dated March 2, 2015 at 2300 note – Caregiver reported wound on members left lateral lower leg. Open blisters were observed. Space provided for Length, Width, Depth and Thickness were blank. • Wound and Skin Assessment Form, dated March 2, 2015, indicate wound Left Lower Extremity, Stage II. The Wound and Skin Assessment Form contained no further documentation of the Left Lower Extremity Stage II Area. • March 5, 2015 at 2:00 p.m. verbal order, written by Wound Care Nurse and co-signed by physician, indicates :D/C Aqua-cel AG, 4x4 and kerlix to left lower leg. To open area left lower leg: xeroform, 4x4 and kerlx. • Nurses Progress Notes dated March 5, 2015 at 2:00 p.m. document – Treatment change to open area left lower leg. • The February 26, 2015 Skin Issue Identification Sheet (Used by Caregivers for documentation of weekly head to toe skin assessment) notes no skin concerns at this time. The next documented Skin Issue Identification Sheet was March 12, 2015 and documentation indicates no changes. • March 13, 2015 at 2:25 p.m. Dietary Progress Record does not include documentation of the Left Lower Extremity Stage II Area. In an interview on March 26, 2015 at 3:00 p.m., the Charge Nurse stated Resident #9 continued to have an area on the Left Lower Extremity. In an interview on March 26, 2015 at 3:15 p.m., the Wound Care Nurse stated pressure areas are assessed and measured every other week. During review of Resident #9"s Wound and Skin Assessment Form with the Charge Nurse and Wound Care Nurse on March 26, 2015 at 3:15 p.m., both confirmed the March 2, 2015			

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			documentation did not include the length and width. The Charge Nurse and Wound Care Nurse also confirmed the Wound and Skin Assessment Form had no further documentation of the Left Lower Extremity Stage II area. March 27, 2015 at 0845 Resident #9 was observed sitting on the side of the bed. Observation with the Charge Nurse, noted a red moist open area midway down the back of Resident #9's Left Lower Extremity. Observation also noted the bed frame made contact with Resident #9's left lower extremity at the point of the Stage II area. Resident #9 stated at this time the area did not hurt and he/she was not sure how the area started. In a discussion immediately following the observation, the Charge Nurse stated Resident #9 had not been evaluated for chair or bed positioning following development of the Left Lower Extremity Stage II area. On March 27, 2015 at 9:00 a.m., the Unit Coordinator confirmed there was not a documented caregiver skin assessment from February 26, 2015 to March 12, 2015. During an interview on March 27, 2015 at 9:05 a.m., the Dietician stated he/she was not aware Resident #9 had a Stage II Area. He/she stated although there is a weekly Team Meeting and a monthly Wound Report there was not a standard as to how he/she is informed when a resident develops a pressure area or what stage pressure areas require a nutritional assessment or intervention. Interview with the LPN (Wound Care Nurse) on 03/26/15 at 1:00pm revealed the wounds are assessed every two (2) weeks by her/him and an assistant. The nurse's wound care training consisted of ten (10) years of hands on experience. Wound Care certification was not obtained or specific wound care training. The assistant is not an assigned wound care nurse but a staff nurse who is				

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			available at the time of rounds. The Wound Care Nurse reported skin issues are reported to her/him immediately when identified upon admission and anytime nursing staff discover new or existing wounds which show a change in skin integrity. The physician visually assesses a wound within 48 hours of a new admission. Wound measurements were once made weekly but are now made every other Tuesday. Treatments and supplies are ordered by the wound care nurse with physician approval. The physician decides on whether to culture the wound or not and the nurse monitors for any changes. Interview with the Infection Control/Wound Care Nurse on 03/27/15 at 10:30am revealed the Infection Control and Wound Care programs were going to be combined and that she/he would be in charge of developing a program that would follow protocols to ensure wound care and infection control worked together for better care and services for all residents. She/he revealed currently there is not a system to follow up with identified wounds and the program is needed. In addition, the facility is large and extra staff would certainly be beneficial in having a system that followed protocols related to wound care treatments. She/He commented more training was needed in order to keep current with the latest techniques in wound care.				
103	e. Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that: 1. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and 2. A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	(M) Met					

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104	3. A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.	(M) Met					
105	f. Range of motion. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and 2. A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.	(M) Met					

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106	g. Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and service	(P) Provisional Met	S/S = D Based on observation, interview, record review, and review of facility policy it was determined that one (1) of 33 sampled residents, Resident # 15, did not have his behaviors managed effectively. He did not receive a referral to mental health services for his behavior problems. Findings Included: Resident #15 was admitted to the facility's Dementia Unit on 01/14/15 with diagnoses of Vascular Dementia, Status Post Heart Transplant, End Stage Renal Disease, Hypertension, Gastro-esophageal Reflux Disease, Other Fracture (Rib Fracture) and Vitamin B Deficiency per the Admission MDS completed on 01/26/2015. A Brief Interview for Mental Status (BIMS) was completed that identified the resident's cognitive status to be scored at 8, on a scale of 1-15, reflecting moderate impairment, (scale range 8-12). The Resident Mood Interview identified a total severity score of 20 on a scale between 0 and 27 indicating severe depression. Symptoms present included feeling down, depressed or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or over eating, feeling bad about yourself- or that you are a failure or have let yourself or family down, moving or speaking so slowly that other people could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual nearly every day, thoughts that you would be better off dead, or of hurting yourself in some way with a frequency of half or more of the days assessed. The MDS assessment identified resident #15 had physical and verbal behavioral symptoms directed toward others occurring 1 to 3 days. The impact on others reflected the identified symptoms put others at significant risk for physical injury, significantly intruded on the privacy or	<insert CAP details here>			

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			activity of others and significantly disrupted care or the living environment. Further behavior was the presence of rejection of care occurring 1 to 3 days. Wandering behavior was scored at 0 or not exhibited. The interview for daily preferences identifted it was very important for this resident to choose what clothes to wear, take care of his personal belongings or things, choose his own bedtime, have his family or a close friend involved in discussions about his care and to have a place to lock his things to keep them safe. Activity preferences identified it was very important to have books, newspapers and magazines to read, to keep up with the news, to do things with groups of people, to do his favorite activities, and to go outside to get fresh air when the weather was good. The MDS assessment identified resident # 15's functional status as independent with activities of daily living with supervision of one person with locomotion off the unit and oversight with eating and personal hygiene. A fall with a fracture was coded prior to admission. A fall assessment, completed on 1/14/15 identified a history of falls, was oriented sometimes, had a steady gait and never had agitated behavior in the past 90 days, or since admission. Review of the Interdisciplinary Progress Record reflects resident #15 was admitted to the Dementia unit 1 Blue at 9:30 AM on 1/14/15 unaccompanied by family via transfer from an acute care facility. An entry time of 2130 states, out with daughter for supper and went to the store. Returned at 6:46 PM. At 7 PM a CNA heard resident yelling for help related to another resident who wandered into his room. Told the wandering member he "will kick his a-ss". CNA removed the other resident and a stop mesh gait was applied to his room. An entry for 1/15/15 states the resident told staff that someone stole his pants and if he found out who stole them or if he				

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			saw them on someone he would take them from him. He was angry and confused and looking for his clothes. A note of 1/16/15 states he was out with his daughter at 2 PM and came back at 5:30 PM and told staff he would rather be homeless than living here. He said the VA is going to be investigated because they are taking $7,000 a month from these guys. On 1/17/15 an entry at 8:10 AM states "this member is stating that he "popped" another member in the face twice. He was in my room by my bed, messing with my stuff". Resident had stated this to other caregivers as well. He was up at the desk requesting to speak with his daughter and left a phone message for her to "come and get me, I don't belong here". At 11:00 AM was moved to another Dementia Unit, 1 Red. At 6:00 PM came out of the dining room upset saying he "can't eat that garbage". Walked down to his room angry. Offered a sandwich and an alternative meal, which he refused, saying "I'm never going to eat here again". "It's no wonder you are under investigation when all you feed people is garbage". Up to the desk and talked with daughter on the phone, saying "I'm going to have a breakdown". "I thought it would be OK when they moved me to a different room until the food came". He called his brother saying he was going to have a breakdown and "so is Sam" (his daughter). "We need some help". On 1/18/15 an entry documents 9 bottles of medication were removed from his room. 1/20/15 an entry reflects he told staff he does not have dementia and his daughter thinks she is the guardian of him. 1/22/15 entry states, another member approached this member. He became upset and raised his fist. Members were separated. Interdisciplinary Progress Record dated 1/27/15 states Care Conference held. We discussed. The resident is to be transferred to an open unit. He is doing well with directions. Dr				

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			informed. Resident states he cannot stay on a restricted unit for much longer. "I need my freedom". Message left for daughter, who is the legal guardian. 1/29/15 note says, resident moved to floor, 2 South. 1/30/15 note states 3 South LPN guides member back to 2 South. He is walked back to unit by a 2 Red caregiver after he thought 2 Red was his unit. Yesterday at 6 PM he went out the South hall door setting off that alarm. He's found by security out front after he thought "it's too cold" out in front of facility. His facial expression slightly blank like. Today he states "I'm getting all screwed up now". No aggression noted yet. 2/2/15 complains about room- mate masturbating and that he has to leave. Told by RN per note that it would not be a rational decision to leave. Room change planned. He declined stating "I don't want to change rooms and do all this moving around right now". Reassured he does not have to move rooms right now. It is suggested to him to "hang out and relax" for now and perhaps he can see social worker tomorrow and go over concerns. 2/3/15 progress note says today he is claiming somebody has been in his stuff and his debit card and glasses are gone. 2/10/15 note reflects: quick to anger, foul language and behaviors toward med nurse. 2/14/15 note reflects in past few days has been more confused on basic needs/ADL's. Was found in another room using the sink to wash up. States "I really do not know where I am at". 3/4/15 states that he I going to leave and is not productive and wants a job. Explained staff would work on finding him some type of work. A note dated 3/20/15 states resident in dining room arguing with another resident when different resident starts coughing, he starts yelling at the member saying he cannot be around coughing since he's susceptible from his heart issues. He is given rationale for others rights by RN and stands up				

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			and starts yelling "Are you disrespecting me?!" and flips a chair over violently, then abruptly leaves. He then goes out on a trip with activities at the last minute. 3/22/15 note states member suddenly starts yelling verbally threatening toward other members driving by in their motorized chairs, accusing them of "racing around him and trying to bother him". Med nurse intervenes between member and another member. This resident motions as though he'll get up and be violent while stating "you can f-off!" He is overheard stating "I'll put tacks under their tires and give them flats". Accuses another resident of walking in on him during a shower and the RN documents the resident was simply just sitting there watching TV. RN documents, e-mail sent to 7-3 RN and Coordinator re: discussion about possible placement on MCY (Courtyard, Secure unit) due to continued threatening unprovoked aggression toward staff and other members. 3/25/15 RN progress note entered (after surveyor intervention): Late note. This member was admitted in Jan 2015 and he has had documented behavior like aggression since he came to the facility and this behavior has followed him through his transfer to 2 South Unit. The first Social Service note dated 1/28/15 states, had care conference yesterday and he is a good candidate for an open unit. Admission packet was sent in the mail to the daughter. Social services notes dated, 2/2, 2/3, 2/5, 3/4, 3/12, 3/16/, 3/20, 3/23 and 3/24/15 note his desire to leave and attempts to arrange placement elsewhere. A Social service note dated 3/25/15 (after surveyor intervention) states member continues to exhibit verbal aggressive behaviors. Chart reviewed. Address his issues with the doctor. He will be referred to BCS (Behavior Care Services, a contract service) for an evaluation. At this time there is a need for medical intervention. Member is not				

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			therapeutically engaging due to feeling he has no problems. It is documented that he became physically and verbally aggressive this weekend. Care plan reviewed. Will have to modify accordingly. 3/26/15 note message left for guardian/daughter to please contact the staff for verbal approval for psychiatric services due to behavioral problems. Will monitor. CAA Notes dated 1/20/15 notes: 2. Cognitive Loss/Dementia. The member is high functioning and it will be discussed if he could be transitioned to a less secure unit. The care plan will address monitoring for change in cognition. 7. Psychosocial Well-Being. Member struck his roommate on 1 Blue and that necessitated his transfer to 1 Red and so far there have been no serious problems. It is hoped that he can successively transition to an open unit. Care planning will address that. CAA 8. Mood State. He is in the severely depressed range. He has had previous psychiatric treatment. He is not on any psychotropic or antidepressant medications. He mentioned some feelings of wanting to die, but did not voice a suicide plan. He has a roommate who is loud, but it is not too overbearing. This social worker will be discussing a referral to BCS to evaluate him for depression. CAA 9. Behavioral Symptoms note the member has had some behavioral issues, which are showing improvement. Behavioral monitoring is being done and there will be discussion with the member's daughter/guardian regarding a BCS referral. A Care Plan dated 2/2/15 lists a problem with an onset date of 1/30/15 and states he was originally admitted to the dementia unit. He has some difficulties with his transition that has resulted in some impulse control behaviors. Due to his higher level of cognition, he has been moved to a skilled unit. Goal: will adjust to the nursing home environment. Approach:				

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			begin date 1/30/15. #1, Social worker to provide 1:1 time as needed. #2, Contact with guardian as needed. #3, Staff to encourage daily routine. Allow member to make decisions about his routine. #4, Social worker to monitor for changes with mood, behavior and cognition. Staff should inform her of any changes/concerns and do appropriate behavior documentation. #5 the member has not been referred to BCS yet due to his several changes with units. The unit social worker will refer if depressive and behavioral issues persist and if he is not responding to other treatment options. #6 Allow member to reminisce. He enjoys interactions with others. #7 give the member praise and affirmation. #8 encourage the member to discuss feelings, thoughts and concerns. Keep the social worker informed of serious issues to enable her to address them in an appropriate and timely manner. Handwritten entry dated 3/22: #9 during aggression remove from others to a quiet place and have member sit down, then staff can sit and have a Q & A period with rationale for consequences provided to suit member's ability to process information. Handwritten entry dated 3/24 BCS consult order, refer to disability advocates for other community placement, provide reassurance as to reduce his verbal aggression. Allow as much independence in ADL's as possible. A Care Conference Form dated 1/27/15 listed the attendance of 2 Social Workers, an RN, RD, Activity Aide and MDS Nurse. The list of 4 issues identified at the care conference was blank. The plan to address issues was also blank. A monthly summary, MDS assessment dated 1/27/15, Area cognition: short term and long term memory problems Okay. Decisions consistent/reasonable and decisions poor/requires supervision. No behaviors present. MDS Assessment Area E. Mood and Behavior: None.				

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			Problem: #1 Self-care deficit related to cognitive impairment. Goal: participate in self-care activities. Goal met. Member is up daily and dressed nicely. Will converse with other members and staff. #2 High risk for falls related to poor safety awareness secondary to cognitive deficit. (Fall risk assessment was 8 denoting low risk.) #3 involuntary weight gain related to presence of edema. The second monthly MDS assessment summary dated 2/12/15 noted no behaviors present and under MDS Code E: Mood and Behavior: Delusions, has odd ideas about this place, physical and verbal behavioral symptoms directed toward others. CP #2 Depression related to need for placement, #4 shows little if any interest in activities. The third monthly MDS assessment summary dated 3/14/15 noted difficulty making decisions, and was otherwise the same as the previous summary. No Behavior Monitoring Forms were in the medical record nor could they be produced upon request. After surveyor intervention a behavior monitoring sheet dated 3/25/15 was presented. Under Where did this occur? Jan. Time of event: All shifts. Incomplete. A Care plan dated 3/25/15 was developed after surveyor intervention with onset date 3/25/15 vascular dementia with behavior disturbance. Goal: resident will learn to control his behaviors. Approach: same interventions with addition of refer to BCS if necessary for possible medication intervention. If medication is provided, monitor for effectiveness and side effects. Physician orders dated 3/25/15 (after surveyor intervention) reflect order entered by Physician for BCS referral re: Dementia and Aggression. Observations were completed 3/24/15 on the 2 South Unit where this resident repeatedly approached the nursing station in an agitated/aggressive state,			

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			wanting to leave the facility and insisting his daughter be called. His daughter was called from the desk and the resident spoke with her after the social worker gave him the phone. The social worker stated that would calm him down, however, after hanging up he continued to pace back and forth and loudly proclaiming his displeasure. The RN Coordinator informed the Social Worker of his behaviors to date and she said she did not know he had any of these behaviors, but, had been working on finding him placement in the community. The consent for the BSC evaluation and treatment was not obtained, but a message was left for the daughter to contact the facility. Interviews with the RN Unit Coordinator, Unit Social Worker and Director of Social Work on 3/24/15 reflected that BCS consents for evaluation and treatment are obtained on admission to the Dementia Unit with the consent for treatment and other admission paperwork. The Director of Social Work stated "we dropped the ball here; it should have been obtained in the Dementia Unit and a referral made for evaluation and treatment." The Unit Social Worker stated "I didn't know he hit someone downstairs", "Nobody told me". Interview with this resident on 3/24/15 was attempted and he replied in an agitated manner "I don't know what is going on here". Another resident, in a wheelchair, on 2 South, approached myself on 3/24/15 and whispered, "he is a TM". When asked what TM stood for he replied "Trouble Maker", then said, "he (identified resident # 15) picked up a chair and threw it at another resident in the dining room this weekend because he was coughing and yelled at him to stop coughing". "The nurse told him not to do that but he doesn't listen". "No, it didn't hit him". Interview with the DON on 3/25/15 revealed she was not familiar with this resident. Upon record review, the				

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			DON stated "he should not have been moved from the Dementia Unit". "He needed to be assessed by BCS (Behavioral Care Services) for evaluation and treatment when he was admitted to the unit with behaviors". "The physician and daughter needed to be notified and consent obtained for BCS". "There were plenty of opportunities for the consent to be obtained from the daughter (legal guardian) and we still do not have the consent". "I am going to be reviewing this chart with the staff because this is a good example that shows these resident assessments and care plans are not accurate". "The care plans are both not developed and complete". "The care plan was not followed and we need re-education here". "No, this does not meet the professional standards of quality". "Mr. ...did not receive appropriate treatment and services for his mental and psychosocial adjustment difficulty". "We need to do better". Review of Interdisciplinary Team progress notes and social service notes associated with the admission assessment revealed the significant behaviors were not noted and changes to the care plan specific to the resident's current status were not planned. A review of the facility's Behavior Management: Managing Untoward Behavior of a Member policy, (effective 10/30/14) revealed the purpose of the policy was to ensure the members displaying undesirable behaviors are managed effectively. When a behavior is observed, the caregiver or nurse will start a Behavioral Monitoring/Intervention Flow Record (Behavior Sheet) and start a new one each time for each behavior. At weekly interdisciplinary team meetings, member behavioral issues will be discussed and plans will be created and or reviewed to deal with behavioral issues. Behavioral plans will be placed in the member's care plan and specific interventions on the				

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			caregiver flow sheet. The team will inform the physician and document in member's chart if behaviors are not responding to the member's behavioral plan. The physician will make recommendations regarding the behavioral plan and/or consider the use of medications to work in conjunction with the behavior plan. Any member having behavior problems will be referred to Behavioral Care Solutions (BCS). The facility failed to manage the resident's undesirable behaviors effectively. Behavioral Monitoring/Intervention Flow Record (Behavior Sheet) was not initiated. There was no documentation of weekly interdisciplinary team meetings to reflect the discussion of behavioral issues, nor were plans created to deal with behavioral issues. No documentation was present regarding notification of the physician of the behaviors exhibited. The physician notes/orders did not reflect recommendations regarding the behaviors or the consideration of the use of medications. The resident was not referred to Behavioral Care Solutions. The surveyor intervened and a physician order dated 3/25/15 was written. The facility failed to obtain consent from the legal guardian on 3/25/15, although the social worker had communication with the daughter who was the legal guardian.				

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107	h. Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that: 2. A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills. 1. A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings were unavoidable; and	(M) Met					

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108	i. Accidents. The facility management must ensure that: 1. The resident environment remains as free of accident hazards as is possible; and 2. Each resident receives adequate supervision and assistance devices to prevent accidents.	(N) Not Met	S/S = G Based on observation, interview, record review, and review of facility policy it was determined three (3) of 33 sampled residents (Resident #5, #19 and #33) did not receive adequate supervision to prevent accidents. 1. Resident #5 required one-on-one supervision due to wandering into other resident's rooms and facing the potential of being injured. Staff assigned to provide the resident were not trained regarding the resident's supervision level. The staff person assigned to provide supervision for Resident #5 on 04/20/14 was not trained and allowed the resident to wander into another resident's room. The staff person called for assistance and a second staff person entered the room and hurried the resident toward the doorway. Resident #5 fell and sustained a fractured left humerus. 2. HS (Nursing) Supervisor did not make sure, after coming into the unit, that the door was secured. Resident #19 was able to stop/prevent door from closing and propelled self off the secured unit. 3. A member of the housekeeping staff at the facility opened the unit door for Resident #33, letting the resident leave thinking the resident was a visitor. This standard is cited at actual harm level. The Findings Included: 1. Review of the facility policy for one-on-one observation (effective 09/22/14) revealed the purpose was to provide guidelines for staff assigned to provide one-on-one observation to members who may be at risk for injury to themselves or others. The policy specified that the Charge Nurse would give instructions to the person selected to complete the one-on-one assignment at the beginning of their designated time for observation, including why the resident has a one-on-one observation order and what specific behaviors to be attentive to. Resident #5 was admitted to the	<insert CAP details here>			

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			facility on 05/20/04 with diagnoses to include Dementia, Alcoholic Brain Disorder, Psychotic Disorder, and Hypertension. A significant change minimum data set (MDS) was conducted on 05/07/14. The resident was identified to be severely impaired in cognition. The assessment indicated the resident experienced two (2) falls during the assessment period, sustaining major injury during one (1) of the falls. The assessment identified Resident #5 to have exhibited verbal and other behavioral symptoms directed toward others during the assessment period. The behavioral symptoms were identified as putting the resident and other residents at risk for physical harm. A review of the care plan revealed the intervention of one-on-one supervision was planned to address the resident's behavioral symptoms. Review of the medical record revealed a physician's order, dated 03/10/14 to initiate one-on-one supervision for safety related to the resident's intrusive behaviors. Review of a physician's progress note, dated 03/13/14 revealed a psychological consultation was obtained because of a recent flare in the resident's intrusive, objectionable behaviors that resulted in a violent response from at least two (2) different residents on the unit. The physician documented the use of medication to over sedation was not ideal and the only reasonable solution would be a "near" one-to-one monitoring. Review of the medical record revealed an incident report dated 04/20/14 at 6:25 p.m. described a witnessed fall sustained by Resident #5. The report included a supervisory analysis documented by the Unit Charge Nurse. According to the report the resident was in the wrong room in another resident's bed. The staff person assigned to provide one-on-one supervision was not familiar with Resident #5 and put the call light on to call for assistance. A second care				

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			giver entered the room and the resident resisted getting out of the bed. The second care giver pulled the resident out of the bed. According to the staff person assigned to provide one-on-one supervision, the resident was walking out of the room and the second care giver kept pushing the resident on the back which caused the resident to fall on his/her left elbow. The resident's elbow became swollen and ice was applied. The nurse assessed the resident's left elbow and the resident screamed in pain when the nurse touched the arm, from the wrist to the elbow. The physician was called and the resident was transferred to the hospital. The second care giver documented on the incident report that he/she was called to the room to remove Resident #5. The resident was resisting and the second care giver pulled to get the resident going. The resident then tripped on his/her feet and fell. Review of a physician's progress note, dated 04/21/14 revealed the physician documented that Resident #5 had experienced a fall the previous evening when exiting another resident's room. The physician noted the resident had a habit of wandering into rooms not assigned to him/her (Resident #5), invading other resident's spaces and frequently needed to be redirected. The progress note stated apparently the resident was on one-on-one nursing observation because of this behavior. The physician documented the resident fell to the floor on his/her left side resulting in a new onset of distal left humerus fracture. An interview was conducted with the Director of Nursing (DON) on 03/25/15 at 5:05 p.m. The DON stated an investigation into the incident involving Resident #5's fall on 04/20/14 with a sustained left humerus fracture was investigated. According to the DON a video from the hallway showed the resident falling from inside the room and into the hallway. The video				

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			supports that the resident was not pushed by staff and an allegation of abuse could not be substantiated. The DON stated the LPN assigned to provide Resident #5 with one-on-one supervision had been employed for only a couple of days prior to the incident and was not comfortable with the assignment of providing one-on-one supervision for Resident #5. The LPN reported later being afraid of being hit by the resident and so would follow the resident at a distance. The DON stated the LPN thought the resident was being closely supervised due to a history of aggressive behaviors and did not realize the assignment was to keep Resident #5 from wandering into other resident's personal space. The DON stated when staff arrive on the unit to provide one-on-one supervision they (staff) should be told why the service is being provided. The DON stated the LPN assigned to provide one-on-one supervision at the time of the incident had resigned from the facility a few weeks later. Interview was conducted with the Unit Nurse Coordinator on 03/25/15 at 10:00 a.m. The Coordinator stated Resident #5 had a physician's order for one-on-one supervision due to a history of incidents where the resident wandered into other resident rooms and being assaulted by the other residents. The Coordinator indicated Resident #5 would resist care at times, however, was never combative or aggressive. The Coordinator stated a "cheat sheet" was kept at the nurses' station that described the one-on-one care givers duties. Staff assigned to provide supervision for Resident #5 were supposed to review the form. A review of the "cheat sheet" revealed daily care and services and activities to be provided was identified. However, the form did not provide staff with directives related to why the resident was receiving one-on-one supervision and what staff should do to intervene when behavioral				

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			symptoms were exhibited. Interview was conducted on 03/24/15 at 9:50 a.m. with a Certified Nurse Aide (CNA). The CNA was preparing to provide Resident #5 with one-on-one supervision during a group activity. The CNA stated he/she was not sure why the resident was receiving one-on-one supervision. Interview was conducted on 03/26/15 at 9:10 a.m. with a CNA who was assigned to one-on-one duties with Resident #5 that day. The resident was seated in a wheel chair and the CNA was seated beside the resident while in the resident's room. The CNA stated he/she had been assigned to provide the level of supervision to the resident on several occasions. The CNA stated however he/she had no idea why the increased supervision level was being provided for Resident #5. 2. Absent Member/Nursing Units Policy, dated December 14, 2014, Policy Statement notes – When a member appears to be absent without leave, nursing and safety staff will implement a defined procedure to locate the member. Resident #19 was admitted to the facility on January 15, 2009 with diagnoses including Anoxic Encephalopathy, Aggressive Behaviors, Agitation, Post Cardiac Arrest, Spastic Ataxia, Agitation, Impulse Control and History of Frequent Falls. According to the resident's Annual Minimum Data Set (MDS) Assessment dated January 13, 2015 Resident #19 cognitive skills were severely impaired. Resident #19 required limited assistance of one (1) person for walking in room and in corridor and limited assistance of one (1) for locomotion on unit and extensive assistance of one (1) person for locomotion off unit. The resident was not coded for behavior symptoms, rejection of care or wandering. Review of Resident #19's medical				

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			record on March 25, 2015 at 2:50 p.m. noted the following: • February 2, 2015 8:00 p.m. Nurses Progress Record indicate – Member anxious, increased ambulation in halls getting out of w/c, going up & down halls, states he is going out those doors & get his car. Staff told member that the weather/roads are bad & he can stay here tonight. Redirected to DR to HS snack. Will continue to observe. • Nurses Progress Record dated February 8, 2015 at 2:45 p.m. note – This nurse was alerted via phone by a Rankin Three (3) member that this member as off the unit unattended. Member was escorted back to the unit unharmed… Supervisory Analysis Section of February 8, 2015 Incident Report - Member indicates HS (Nursing) Supervisor did not make sure after coming into the unit that the door was secured. Member was able to stop/prevent door from closing and propelled self off the secured unit. Safety ran report of back up video to reveal HS Supervisor did not secure door multiple times on/off unit on the video. During an interview on March 26, 2015 at 1100, the Director of Nurses stated although he/she had not reviewed the video, the Assistant Director of Nursing had reviewed the video and confirmed the HS Supervisor had not secured the unit door. Review of the February 8, 2015 Incident Report – Member indicates Analysis completed on February 10, 2015; Review completed on February 28, 2015; Nursing Service/Department Head signature on March 5, 2015 and Administrator signature on March 10, 2015. In an interview on March 27, 2015 at 9:45 a.m., Licensed Staff stated interventions were not implemented following Resident #19's February 2, 2015 comment of going out those doors and getting his/her car and on February 8, 2015 unit staff was not				

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			aware Resident #19 had left the unit so defined procedure for Absent Member was not implemented. Observation with Licensed Staff on March 27, 2015 at 12:00 p.m. noted Resident #19 being pushed in a wheel chair to the Dining Room for lunch. Resident #19 proceeded to eat lunch with built up utensils. Licensed Staff stated at this time, Resident #19 is more independent at times and frequently is able to self propel his/her wheel chair. 3. Review of the clinical record for Resident #33, 69 years old revealed the resident to have diagnoses that include: Alzheimer's, Benign Prostatic Hyperplasia (BPH), Hepatitis, History of Pylori, Psychosis. Resident #33 has moderate to severe cognition impairment but is physically capable to maneuver/ambulate without assist or devices throughout the unit. Resident #33 has exit-seeking behaviors and will stand and wait by doors and leave the unit when the opportunity arises. Observation of Resident #33 on 3/25/15 at 9:30am revealed the resident walking up to the nurse desk asking the whereabouts of a staff nurse while drinking a soft drink. Resident #33 appeared to be an employee of the facility while maneuvering on the unit. Review of the incident report dated 12/11/14 revealed Resident #33 was let off the unit by a new housekeeper (HK) after the resident had asked the HK to open the door. The HK thought the resident was a visitor so she/he opened the locked door to let the resident out. The report stated that Resident #33 asked the HK to open the door and the HK did. Later, Resident #33 was found sitting on a bus in front of the main lobby of the facility. Resident #33 was taken back to the locked unit after he/she was found. Interview with the Nurse Supervisor on 03/25/15 revealed HK employees are contracted with the facility and are				

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			trained on policies and procedures of the facility. The facility reported to the contracted agency the incident of the elopement and the agency stated the employee was new and needed to be retrained not to open any locked entry doors while on the unit. Interview with the contracted agency on 03/25/15 presented this surveyor with a document stating the HK employee involved with the elopement was retrained and not allowed to work on the secured units. Training needs to include all employees, agency included at the facility to ensure adequate supervision for all residents.				
109	j. Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident: 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 2. Receives a therapeutic diet when a nutritional deficiency is identified.	(M) Met					
110	k. Hydration. The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health.	(M) Met					
111	l. Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: 1. Injections; 2. Parenteral and enteral fluids; 3. Colostomy, ureterostomy, or ileostomy care 4. Tracheostomy care; 5. Tracheal suctioning; 6. Respiratory care; 7. Foot care; and 8. Prostheses.	(M) Met					

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112	m. Unnecessary drugs: 1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: i. In excessive dose (including duplicate drug therapy); or ii. For excessive duration; or iii. Without adequate monitoring; or iv. Without adequate indications for its use; or v. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or vi. Any combinations of the reasons above.	(M) Met					
113	2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility management must ensure that: ii. Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. i. Residents 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	(M) Met					
114	n. Medication Errors. The facility management must ensure that: 1. Medication errors are identified and reviewed on a timely basis; and 2. Strategies for preventing medication errors and adverse reactions are implemented.	(M) Met					

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115	§ 51.130 Nursing Services. The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week. a. The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff.	(M) Met					
116	b. The facility management must provide registered nurses 24 hours per day, 7 days per week.	(M) Met					
117	c. The director of nursing services must designate a registered nurse as a supervising nurse for each tour of duty. 2. Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes. 1. Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes.	(M) Met					

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118	d. The facility management must provide nursing services to ensure that there is a minimum direct care nurse staffing per patient per 24 hours, 7 days per week of no less than 2.5 hours.	(P) Provisional Met	S/S: E Based on a review of four separate seven day work weeks of staffing to confirm direct care nurse staffing and ratios proved difficult. The facility was unable to provide member census for seven consecutive days in each week reviewed. In addition, there was a comment by a staff member that a significant number of staff called off for the second weekend of February 2015. We were unable to verify acceptable staffing ratios and hours of direct care nursing staff per patient for that period of time due to the missing census documents. Higher level acuity of care units appeared to have a lower staffing ratio on numerous days.	<insert CAP details here>			
119	e. Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part.	(M) Met					
120	§ 51.140 Dietary Services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. a. Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis. 1. If a qualified dietitian is not employed full-time, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian. 2. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.	(M) Met					
121	b. Sufficient staff. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service.	(M) Met					

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122	c. Menus and nutritional adequacy. Menus must: 1. Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; 2. Be prepared in advance; and 3. Be followed.	(M) Met					
123	d. Food. Each resident receives and the facility provides: 1. Food prepared by methods that conserve nutritive value, flavor, and appearance; 2. Food that is palatable, attractive, and at the proper temperature; 3. Food prepared in a form designed to meet individual needs; and 4. Substitutes offered of similar nutritive value to residents who refuse food served.	(M) Met					
124	e. Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician.	(M) Met					
125	f. Frequency of meals. 1. Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. 2. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in paragraph (f)(4) of this section. 3. The facility staff must offer snacks at bedtime daily. 4. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day, if a resident group agrees to this meal span, and a nourishing snack is served.	(M) Met					

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126	g. Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them.	(M) Met					
127	h. Sanitary conditions. The facility must: 1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; 2. Store, prepare, distribute, and serve food under sanitary conditions; and 3. Dispose of garbage and refuse properly.	(M) Met					
128	§ 51.150 Physician services. A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. a. Physician supervision. The facility management must ensure that: 1. The medical care of each resident is supervised by a primary care physician; 2. Each resident's medical record must list the name of the resident's primary physician; and 3. Another physician supervises the medical care of residents when their primary physician is unavailable.	(M) Met					
129	b. Physician visits. The physician must: 1. Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; 2. Write, sign, and date progress notes at each visit; and 3. Sign and date all orders.	(M) Met					

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130	c. Frequency of physician visits. 1. The resident must be seen by the primary physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or more frequently based on the condition of the resident. 2. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. 3. Except as provided in paragraphs (c) (4) of this section, all required physician visits must be made by the physician personally. 4. At the option of the physician, required visits in the facility after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.	(M) Met					
131	d. Availability of physicians for emergency care. The facility management must provide or arrange for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency.	(M) Met					
132	e. Physician delegation of tasks. 1. Except as specified in paragraph (e)(2) of this section, a primary physician may delegate tasks to: i. A certified physician assistant or a certified nurse practitioner; or ii. A clinical nurse specialist who: A. Is acting within the scope of practice as defined by State law; and B. Is under the supervision of the physician. Note: A certified clinical nurse specialist with experience in long term care is preferred.	(M) Met					
133	2. The primary physician may not delegate a task when the regulations specify that the primary physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.	(M) Met					

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134	§ 51.160 Specialized rehabilitative services. a. Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must: 1. Provide the required services; or 2. Obtain the required services from an outside resource, in accordance with § 51.210(h) of this part, from a provider of specialized rehabilitative services.	(M) Met					
135	b. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	(M) Met					
136	§ 51.170 Dental Services. A facility: a. Must provide or obtain from an outside resource, in accordance with § 51.210 (h) of this part, routine and emergency dental services to meet the needs of each resident; b. May charge a resident an additional amount for routine and emergency dental services; c. Must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the dental services; and 3. Promptly refer residents with lost or damaged dentures to a dentist.	(M) Met					
137	§ 51.180 Pharmacy services. The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 51.210 (h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff.	(M) Met					

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138	a. Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility; 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	(P) Provisional Met	S/S - D Based on observation, interviews and record reviews it was determined pharmacy staff failed to construct Medication Administration Records to assist with the accurate administration of all medications for two (2) Unsampled Residents on one (1) of 12 nursing units (3 South). Findings Included: During a March 25, 2015 at 9:20 a.m., Medication Pass Observation on 3 South, the following Medication Administration Record transcriptions were observed: • Medication Administration Record for Unsampled Resident #1 includes – Baclofen 10mg tablet. Take 4 tablets at 0900, 2100 and 3 Tablets (30 mg) at 1200 Every Day. • Medication Administration Record for Unsampled Resident #2 includes – Levemir 100 Units/ml Vial. Inject Subcutaneously 20 Units at 0800 and 30 Units at 2100. In an interview with the Licensed Staff at that time, the Licensed Staff stated different doses of the same medication were previously separated on the Medication Administration Record but that had stopped at least one (1) year ago. The Licensed Staff stated there was a recent meeting with the Pharmacy Department to discuss this issue because numerous nursing staff did not feel it was safe to list two (2) different doses of the same medication in the same space on the Medication Administration Record. The Licensed Staff stated the Pharmacy Department indicated at the meeting the different doses of the same medication could not be separated on the Medication Administration Record. In an interview on March 25, 2015 at 11:00 a.m., the Assistant Director of Nursing (ADON) confirmed a recent meeting with the Pharmacy Department to discuss listing more than one (1) dose of a medication on the same space of the Medication Administration Record had occurred and the Pharmacy Department did	<insert CAP details here>			

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			indicate this could not be changed. The ADON stated there are residents on all units affected by this process. During an interview on March 25, 2015 at 11:20 a.m., the Pharmacist stated different doses of the same medication were previously separated on the Medication Administration Record but that had stopped some time ago. The Pharmacist stated different doses of the same medication are grouped on the Medication Administration Record because the data entry process is simpler, if the different medication doses are separated it may print on different sheets, billing and physician preference to have all doses of a medication together. The Pharmacist confirmed at this time, he/she was aware of licensed staff concerns. The Pharmacist was unable to identify how many residents in the facility were affected by this process.				
139	b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility; 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	(M) Met					
140	c. Drug regimen review. 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 2. The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon.	(M) Met					

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141	d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the e	(P) Provisional Met	S/S - D Based on observation and interviews, it was determined facility staff failed to develop a system to identify expiration date and specific resident usage of over the counter medications for one (1) of 12 nursing units (3 South). Findings included: During a March 25, 2015 at 9:20 a.m., Medication Pass Observation on 3 South, the following was observed: • Medication cart contained multiple bottles of opened over the counter medications including two (2) bottles of Aspirin 81 mg, two (2) bottles of Vitamin C 500 mg and two (2) bottles of Vitamin D. • None of the opened over the counter medications were labeled with date opened. In an interview with the Licensed Staff at that time, the Licensed Staff stated over the counter medication bottles sometimes are marked with the date opened; sometimes the bottles are not marked. The Licensed Staff was not sure what facility practice required. The Licensed Staff further stated there was not a specific way to determine what bottle of an over the counter medication was used for which resident. He/she stated the medication cart is set up by halls so if the bottle of over the counter medication is stored on one side of the medication cart, it must be for those residents in that hall. He/she did not know how to determine what bottle should be used for which resident if there was more than one (1) bottle of the same medication on the same side of the cart. During an interview on March 25, 2015 at 11:20 a.m., the Pharmacist stated the facility did not have a policy that addressed over the counter medications but he/she believed the opened over the counter medications are good through the manufactures expiration date listed on the bottle. The Pharmacist agreed there should be a means to determine what bottle of	<insert CAP details here>			

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			over the counter medication was being used for what resident. On March 26, 2015 at 10:00 a.m., the Pharmacist relayed he/she had contacted other pharmacist in the area and over the counter medications may be used for one (1) year following the date opened.				
142	e. Storage of drugs and biologicals. 1. In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	(M) Met					
143	2. The facility management must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse.	(M) Met					

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144	§ 51.190 Infection Control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. a. Infection control program. The facility management must establish an infection control program under which it: 1. Investigates, controls, and prevents infections in the facility; 2. Decides what procedures, such as isolation, should be applied to an individual resident; and 3. Maintains a record of incidents and corrective actions related to infections.	(P) Provisional Met	S/S: D Based on observation, interviews and record review, it was determined the facility staff failed to maintain an Infection Control Program that included investigating, controlling and preventing infections. Findings included: Infection Prevention And Control Program (Review Date September 22, 2014) includes: • The primary goal of the Infection Prevention and Control Program is to reduce the risk of infection and reduce the risk of infection transmission, both endemic and epidemic, by acting on opportunities identified through surveillance activities, geographic, and demographic considerations. • Listed Infection Prevention and Control Program Committee Responsibilities/Functions include: 1. As appropriate, recommend intervention to prevent or control infections based on evaluation of infection data or potential for infection. 2. Review information collected during any environmental surveillance activities. Initiate intervention and/or action plan to resolve as appropriate. During an interview on March 25, at 1015 the Infection Prevention and Control Specialist stated the following: • Data related to infections is collected and compiled one week every quarter. The most recently compiled infection control data presented was from the week of September 14 – 20, 2014. The Infection Prevention and Control Specialist stated data for a week in December was collected but had not yet been compiled and analyzed. • Infections are tracked by unit but not trended and analyzed. • Infections are not tracked and trended by specific location on the units. • Infections are not tracked and trended by organisms. • Hospital/Community acquired infection data is not collected and analyzed.	<insert CAP details here>			

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			The Infection Prevention and Control Specialist also stated at this time although there is no supporting documented data, the facility's area of concern are urinary tract infections, oral care and skin infections. He/she has not written, presented or implemented an Action Plan but has begun some interventions such as having tooth brushes donated to the facility. Management And Investigation Of Possible Outbreak/Unusual Occurrence Policy (Review Date January 23, 2015) includes: • In the event surveillance infection data suggests either an outbreak or sentinel event, the Infection Preventionist or designee will initiate an investigation with management as indicated/appropriate. • Develop and implement control measures • Continue with surveillance • Provide testing and prophylaxis The Gastroenteritis Outbreak Response (Review Date November, 2014) includes an outbreak is 10% of Unit – Combination of members and employees and With Doctor Rx, Submit stool specimen for Laboratory analysis. Following the Survey Entrance Meeting on March 24, 2015 at 9:00 a.m., the Infection Prevention and Control Specialist informed the Survey Team that one (1) unit, Main Courtyard, was contained due to a Gastroenteritis Outbreak. During discussion on March 25, 2015 at 10:40 a.m., the Infection Prevention and Control Specialist stated gastrointestinal symptoms were first observed with the Main Courtyard residents on March 19, 2015 and he/she initiated and posted the Gastroenteritis Outbreak Response and initiated containment on the unit on March 21, 2015. The Infection Prevention and Control Specialist then stated containment was initiated on March 22, 2015 by the House Supervisor. During further discussion,				

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			the Infection Prevention and Control Specialist indicated he/she initiated and posted the Gastroenteritis Outbreak Response and initiated containment on the unit on March 24, 2015. The Infection Prevention and Control Specialist indicated at this time Main Courtyard remained contained because although residents continued to have diarrhea, staff had not been able to obtain any stool specimens. Observation of Main Courtyard with the Infection Prevention and Control Specialist on March 25, 2015 at 10:50 a.m. noted the Gastroenteritis Outbreak Response was not posted. Main Courtyard Unit Coordinator and Licensed Staff present at this time indicated the Gastroenteritis Outbreak Response had not been posted and nursing staff was not aware stool specimens were needed.				

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145	b. Preventing spread of infection: 1. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. 2. The facility management must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. 3. The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	(P) Provisional Met	S/S - E Based on observation and interview it was determined facility staff did not always wash their hands after each direct resident contact on three (3) of 12 nursing units (Main Courtyard, One Rankin and Three South). Findings included: During an interview on March 25, 2015 at 1015 a.m., the Infection Prevention and Control Specialist indicated hand hygiene and resident contact are an important part of infection control. Hand hygiene is monitored with scheduled Mock Survey Rounds and on a random basis. The facility was unable to provide a policy for hand washing hygiene. Observation of the Main Courtyard (Unit with the Gastroenteritis outbreak) noon meal service on 03/25/15 revealed the direct care staff were not always washing their hands between handling trash and the trash can and providing residents with assistance with the meal service. Two (2) direct care staff persons were observed during separate incidents to remove paper items from resident trays and carry the trash to a trash can located in the dining area. Each of the direct care staff persons were observed after touching the lid of the trash can to return to residents and provide assistance with the meal service without first washing their hands. Interview was conducted with the Unit Nurse Manager on 03/25/15 at 12:30 p.m. while in the dining room. The infection control breach was pointed out to the manager who immediately approached the direct care givers about washing their hands. According to the Nurse Manager staff are trained to wash their hands between each resident contact. Observation of One Rankin lunch meal on March 25, 2015 at 12:05 p.m., with the licensed staff and Charge Nurse, noted two (2) direct care staff serving lunch to 13 residents seated in the unit dining room. Both direct care staff wore gloves. Both direct care staff	<insert CAP details here>			

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			touched carts, tables, chairs, trays and other residents while preparing the residents for lunch without changing gloves between residents. The observations were confirmed by the licensed staff and Charge Nurse on March 25, 2015 at 12:05 p.m. Observation of Three South lunch meal on March 25, 2015 at 12:40 P.M. noted four (4) direct care staff serving lunch to 16 residents seated in the unit dining room. One (1) direct care staff opened the cart door, removed the tray, touched the doorway, a chair, touched the resident, set up the tray and proceeded to the cart. The direct care staff removed a tray and proceeded to set the tray up for another resident without completing hand hygiene. The observation was confirmed by a licensed staff present at the time of the observation.				
146	c. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	(M) Met					
147	§ 51.200 Physical environment. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. a. Life safety from fire. The facility must meet the applicable provisions of the 2009 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference).	(M) Met					

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148	b. Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition). (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Standard for Health Care Facilities (2005 edition). (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition).	(M) Met					
149	c. Space and equipment. Facility management must: 1. Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and 2. Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	(M) Met					

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150	d. Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents: 1. Bedrooms must: i. Accommodates no more than four residents; ii. Measure at least 115 net square feet per resident in multiple resident bedrooms; iii. Measure at least 150 net square feet in single resident bedrooms; iv. Measure at least 245 net square feet in small double resident bedrooms; and v. Measure at least 305 net square feet in large double resident bedrooms used for spinal cord injury residents. It is recommended that the facility have one large double resident bedroom for every 30 resident bedrooms. vi. Have direct access to an exit corridor; vii. Be designed or equipped to assure full visual privacy for each resident; viii. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; ix. Have at least one window to the outside; and x. Have a floor at or above grade level.	(M) Met					
151	2. The facility management must provide each resident with: i. A separate bed of proper size and height for the safety of the resident; ii. A clean, comfortable mattress; iii. Bedding appropriate to the weather and climate; and iv. Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	(M) Met					

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152	e. Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities. It is recommended that public toilet facilities be also located near the resident's dining and recreational areas.	(M) Met					
153	f. Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from: 1. Resident rooms; and 2. Toilet and bathing facilities.	(M) Met					
154	g. Dining and resident activities. The facility management must provide one or more rooms designated for resident dining and activities. These rooms must: 1. Be well lighted; 2. Be well ventilated; 3. Be adequately furnished; and 4. Have sufficient space to accommodate all activities.	(M) Met					
155	h. Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must: 1. Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	(M) Met					
156	2. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;	(M) Met					
157	3. Equip corridors with firmly secured handrails on each side; and	(M) Met					
158	4. Maintain an effective pest control program so that the facility is free of pests and rodents.	(M) Met					

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Caleb.Hart_Gra _____

Curtis.Bruer_Gra _____

Debra.Wilcox_Gra _____

Eric George _____

Lisa Martin _____

Michelle.Crawford_Gra _____

Patricia Steward2 _____

Patricia.Beckmann_Gra _____

Susan Honaker _____

Department of Veterans Affairs - (Standards - Domiciliary)

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SURVEYED BY (VHA Field Activity of Jurisdiction)

Caleb.Hart_Gra Curtis.Bruer_Gra Debra.Wilcox_Gra Eric George Lisa Martin Michelle.Crawford_GraPatricia Steward2 Patricia.Beckmann_GraSusan Honaker

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159	1. Governance and Operation The facility is governed and managed effectively. A. The facility has a governing body or designated persons so functioning with full legal authority and responsibility for the operation of the facility.	(M) Met					
160	B. Written administrative policies, procedures, and controls are established, implemented and reviewed at least annually to promote the orderly and efficient management of the facility.	(M) Met					
161	C. There are sufficient, knowledgeable administrative and clinical staff assigned to provide quallity care within the domiciliary.	(M) Met					
162	D. Written personnel policies and procedures are established and implemented to facilitate sound patient care and personnel practices.	(M) Met					
163	E. The facility has an ongoing staff development program including orientation of new employees and inservice education related to the needs and care of domiciliary patients.	(M) Met					
164	F. There is evidence of input from all services to management by regular meetings and systematic review of the domiciliary program.	(M) Met					
165	2. Safety. The facility shall be structinally safe and maintained to protect the health and safety of patients, personnel and visitors. A. The facility has a current State Fire Marshall's certificate or documented evidence of compliance with life safetycodes.	(M) Met					
166	B. The facility has a current report by a qualified VA Life Safety engineer or specialist that the facility is in compliance with the provisions of the Life Safety code currently in force, applicable to domiciliaries.	(M) Met					

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167	C. There is evidence that reported life safety deficiencies have been or are being corrected.	(M) Met					
168	D. The facility has available an emergency source of electrical power to provide essential service when normal electrical supply is interrupted.	(M) Met					
169	E. The buildings are accessible to and safe for persons with handicaps.	(M) Met					
170	F. The facility has a program for prevention and control of infection.	(M) Met					
171	G. Linens are handled, stored, processed and transported in such a manner as to maintain a clean environment and prevent infection.	(M) Met					
172	H. The facility has an ongoing program of integrated pest management	(M) Met					
173	I. Cleaning agents, maintenance supplies and pesticides are stored under safe and sanitary conditions.	(M) Met					
174	3. Physical Environment. The facility provides a fnctional, aesthetically pleasing, sanitory, and comfortable environment for patients, personnel, and visitors. A. The facility employs a supervisor of sanitation with sufficiently trained personnel to maintain a safe, clean and orderly environment.	(M) Met					
175	B. The buildings are maintained in a clean, attractive, and comfortable manner.	(M) Met					
176	C. Acceptable practices are employed for maintenance and repair of equipment, buildings, and grounds.	(M) Met					
177	4. Medical Care. There is a comprehensive ambulatory medical care program designed to meet the needs of domiciliary patients. A. The facility ensures the provision of professional medical services for the patients.	(M) Met					
178	B. Each patient has a primary physician responsible for the patient's medical care.	(M) Met					
179	C. Patients are classified according to domiciliary care required.	(M) Met					
180	D. A patient treatment plan is established and maintained for each domiciliary patient.	(M) Met					

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181	E. Primary Care medical services are provided for domiciliary patients as needed.	(M) Met					
182	F. Each patient has a complete medical re-evaluation annually and as needed.	(M) Met					
183	G. There is provision made for preventive and maintenance dental and other health services.	(M) Met					
184	H. Transportation is available for patients needing medical, dental and other health services.	(M) Met					
185	I Domiciliary patients are admitted to an infirmary when necessary.	(M) Met					
186	J. There is a written agreement with one or more hospitals to accept a patient requiring hospitalization.	(M) Met					
187	K. Domiciliary patients are admitted to nursing home care or hospital care if medically necessary.	(M) Met					
188	5. Nursing Care. The facility maintains an organized nursing service with nursing personnel qualified to meet the nursing care needs of the domiciliary patient. A. A full-time qualified registered nurse is responsible for the nursing services provided the patients.	(M) Met					
189	B. Primary Care nursing services are provided for domiciliary patients.	(M) Met					
190	C. Nursing services rendered are documented in the patient's medical record.	(M) Met					
191	D. Nursing Service participants in the establishment and maintenance of a treatment plan for each domiciliary patient.	(M) Met					
192	E. The facility providesfor 24 hour nursing services as required to meet the nursing care needs of the domiciliary patient.	(M) Met					
193	6. Rehabilitation. Rehabilitation services are provided as needed to improve and maintain maximum functioning of each domiciliary patient. A. The facility provides, or arranges for under a written agreement, rehabilitation services as needed by the patient.	(M) Met					
194	B. Rehabilitation services are provided under a written plan of care for each patient.	(M) Met					

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195	C. Specialized rehabilitation therapy rendered, progress notes, and evaluation of the treatment plan are recorded in the patient's medical record.	(M) Met					
196	7. Social Services. The facility provides professional social work services to identify and meet the social and emotional needs of patients. A. A qualified social worker is on staff or the facility has a written agreement with a quallfied social worker or recognized social agency for consultation on a regularly scheduled basis.	(M) Met					
197	B. A written psychosocial assessment is maintained in each patient's medical record.	(M) Met					
198	C. Results of social services rendered are documented in the patient's medical record.	(M) Met					
199	D. The facility has an organized procedure for discharge and transfers.	(M) Met					
200	8. Dietetics. The facility provides a dietetic service that meets the daily nuritional needs of patients and ensures that special dietary needs are met. A. The dietetic service is under the direction of a qualified dietitian or a full-time dietetic service supervisor with consultation from a qualified dietitian.	(M) Met					
201	B. Menus, to extent medically possible, are planned in accordance with the Recommended Dietary Allowances (RDA) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.	(M) Met					
202	C. Special diets are available as needed.	(M) Met					
203	D. At lease three or more regular meals are served daily, with not more than a 14- hour span between substantial evening meal and breakfast.	(M) Met					
204	E. Dietetic service personnel practice safe and sanitary food handling techniques.	(M) Met					
205	F. Dining areas are large enough to accommodate all domiciliary patients.	(M) Met					
206	G. The nutritional status of each patient is monitored on a regular basis.	(M) Met					

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207	9. Patient Activities. An activities program is available to the domiciliary patients and designed to enhance each patient's sense of physical, psychological, and spiritual well being. A. A member of the facilities staff is designated as responsible for the patient activities program.	(M) Met					
208	B. Space, equipment, and supplies for the activities program are adequate for individual and/or group activities.	(M) Met					
209	C. There are regularly scheduled activities during weekdays, evenings and weekends.	(M) Met					
210	D. Each patient's activity plan is part of the overall treatment plan.	(M) Met					
211	E. Religious services and spiritual activities are provided for patients.	(M) Met					
212	F. Domiciliary patients are encouraged to participate in supervised community activities.	(M) Met					
213	10. Pharmacy. Pharmaceutical services meet the needs of patients and are provided in accordance with ethical and professional practices and legal requirements. A. A registered pharmacist is responsible for pharmacy services.	(M) Met					
214	B. A program is established for the safe procurement, control, and distribution of drugs.	(M) Met					
215	C. There is controlled access to all drugs and substances used for treatment.	(M) Met					
216	D. Patient on self-medication are instructed by qualified personnel on the proper use of drugs	(M) Met					
217	E. Provision is made for qualified nursing personnel to administer medication to patients who are not in a self-medication program.	(M) Met					
218	F. There is an established system for monitoring the outcome of drug therapy or treatment.	(M) Met					

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219	11. Medical Records. The patient's health status is documented regularly in the medical record in accordance with the treatment plan. A. Medical records are completely legible and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.	(M) Met					
220	B. The facility safeguards medical record information against less, destruction or unauthorized use.	(M) Met					
221	C. The medical record contains sufficient information to clearly identify the patient.	(M) Met					
222	12. Quality Assistance. The facility has an active quality assurance program in the domiciliary to ensure efffective utilization and delivery of patient care services.A. A member of the facilities staff or facility committee is designated as responsible for coordinating the quality assurance program.	(M) Met					
223	B. The quality assurance program emcompasses reviews of all services and programs provided for the domiciliary patients.	(M) Met					
224	C. The quality assurance program encompasses ongoing utilization review.	(M) Met					
225	D. The quality assurance program is revaluated at least annually.	(M) Met					
226	13. Quality of Life. The domiciliary level of care fosters a quality of life conductive to self esteem, security, and personal growth. A. Patients are treated with respect and dignity.	(M) Met					

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227	B. There is input to the domiciliary program through a patient advisory council.	(N) Not Met	Based on resident group interview and staff interview, the facility failed to act upon the concerns of residents and the resident council regarding resident care and life in the facility by providing access to and effective ombudsman/ advocacy program. The findings include: A review the council minutes for May 2014 revealed that domiciliary residents inquired about an ombudsman representative. According to the group minutes, residents noted that the person listed as their ombudsman was actually not their ombudsman. Further review of the minutes for 2014 revealed that the concern regarding advocacy was consistent. A group interview meeting with residents residing in the domiciliary was conducted on March 25th at approximately 10:10 AM. Domiciliary residents stated that they had written letters to government officials regarding issues with care at the facility. Residents presented letters that they had written to state senators about their grievances and also presented copies of articles written about the issues surrounding staffing and care at the facility. An online search confirmed the residents had expressed their concerns regarding conditions at the facility and the state representatives called for an investigation in the home regarding the lack of care provided to the resident members in 2013. Domiciliary residents also stated that they had issues with a particular nurse who verbally berated them and would not assist them with nursing services. A review of the grievances filed by domiciliary residents confirmed that residents had expressed fear, disrespect and harassment from a head nurse. Further review of the grievances revealed that the nurse in question was given at least one written reprimand for verbal comments made to a resident. In another grievance the nurse was asked to completely	<insert CAP details here>			

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			investigate resident incidents before taking disciplinary actions. In both instances, residents claimed that they were disrespected and harassed. An interview with the Administrator was conducted on 3/26/15 at approximately 5:30 PM. The Administrator revealed the current long term care ombudsman stated that his purpose was to handle issues with skilled nursing residents. The Administrator added that the ombudsman stated that he would address issues from domiciliary residents only if approached. An interview was conducted via phone with the Michigan Office of Services to the Aging (OSA). The state long term care ombudsman office explained that the domiciliary was not licensed and was not covered by the current ombudsman. The office staff provided veteran's assistance contact information for the county that the facility resides in.				
228	C. A homelike environment is provided.	(M) Met					
229	D. The facility has written policies and procedures concerning the rights and responsibilities of the domiciliary patient.	(M) Met					
230	E. Patients are oriented to the policies and procedures of the domiciliary on admission.	(M) Met					
231	F. Patients may manage personal financial affairs or are given an accounting as required by state law, of financial transactions made on their behalf.	(M) Met					

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