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	ALR-0001	A. BUILDING: _____ B. WING _____	12/14/2018

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R 000	Initial Comments An annual survey was conducted on 12/11/18 through 12/14/18 to determine compliance with the Assisted Living Law. The Assisted Living Residence provided care for 39 residents and employed 32 personnel to include professional and administrative staff. The findings of the survey were based on observations, record reviews, and interviews. Listed below are abbreviations used throughout the body of this report: ADL- Activites of Daily Living ALR- Assisted Living Residence BP - Blood Pressure CNA- Certified Nursing Assistant DON - Director of Nursing ER- Emergency Room F- Fahrenheit IDT - Interdisciplinary Team ISP - Individualized Service Plan H&P- History and Physical LPN - Licensed Practical Nurse MAR- Medication Administration Record mg- milligrams mmHg- millimeters of mercury OT- Occupational Therapist O2 - Oxygen PDA- Private Duty Aide PRN- as needed PT- Physical Therapist	R 000		
R 292	Sec. 504.1 Accommodation Of Needs. (1) To receive adequate and appropriate services and treatment with reasonable accommodation of individual needs and preferences consistent with their health and physical and mental capabilities and the health or safety of other residents;	R 292		

Health Regulation & Licensing Administration

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R 292	Continued From page 1 Based on observation, interview, and record review, the ALR failed to ensure a staff LPN had knowledge of how to safely administer anti-hypertension medication, assess a resident for change in status, and make the physician aware of the residents change in status for one of four residents in the sample (Resident #4). Findings included: During the observation of medication administration on 12/12/18 at 1:00 PM, LPN #1 obtained Resident #4's BP via an electric blood pressure cuff before attempting to administer the resident's prescribed anti-hypertensive medication (Lisinopril 10 mg). The blood pressure cuff measured the resident's BP at 136/44 mmHg (normal BP 120/80 mmHg per American Heart Association 2017). LPN #1 prepared Lisinopril 10 mg to administer to the resident. When the surveyor asked LPN #1 about the resident's BP, the LPN stated "it usually runs low, but this was the lowest [she] had ever seen it." The surveyor then asked LPN #1 if she would administer the Lisinopril (lowers blood pressures) with the resident's low diastolic pressure of 44 mmHg. The LPN responded, "Yes, because I don't have parameters to hold the medication for a low diastolic pressure." Continued observation revealed that Resident #4 was complaining of having a temperature and not feeling well. LPN #1 measured the resident's temperature orally and received a reading of 98.7 degrees F. It should be noted that the resident was receiving 02 via nasal cannula, which can skew oral temperature readings. The LPN was asked if she used another route to measure temperature when a resident was receiving O2 via nasal cannula. The LPN stated that she takes the temperature orally. Additionally, LPN #1 failed to assess the	R 292	R292 1) LPN #1 was immediately removed from direct resident care and re-educated on the blood pressure protocol, critical thinking, and when a resident is using oxygen, use other route than oral to take the temperature. 2) We will re-educate licensed nurses to include blood pressure protocol, critical thinking, and when a resident is using oxygen, use other route than oral to take the temperature. 3) 10% of records of the residents that receive blood pressure medications will be audited weekly x4, monthly x3 and quarterly to ensure that blood pressure medications are administered safely.	12/12/2018 01/31/2019 Ongoing

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R 292	Continued From page 2	R 292		

resident's complaint of not feeling well. Based on these collective observations, the surveyor then asked LPN #1 to call the Nurse Coordinator and hold all medications for Resident #4.

The Nurse Coordinator came and reassessed Resident #4's BP with a manual cuff and measured a tympanic temperature. The resident's BP was 140/58 mmHg and temperature was 100.6 degrees F. The Nurse Coordinator then instructed LPN #1 to hold the Lisinopril 10 mg, administer PRN Tylenol 1000 mg, and call the physician to report the resident's change in status.

Review of the November 2018 and December 2018 MAR on 12/12/18 at 2:00 PM revealed that the lowest diastolic BP measured for Resident #4 was 50 mmHg and was recorded on two occasions, 11/27/18 and 11/30/18. Continued review of the MARs revealed that the resident's diastolic pressure fluctuated between 50mmHg and 99 mmHg. The MARs also indicated parameters to hold Lisinopril for systolic BP less than 110 mmHg.

Review of the facility's Blood Pressure policy showed that [staff] should hold medication "if any of the resident blood pressure values are low."

During an interview on 12/12/18 at 3:00 PM, the DON stated that LPN #1 should have known to hold the Lisinopril because of the resident's low diastolic BP of 44 mmHg. The DON also explained that LPN #1 was removed from direct resident care until additional training and re-education could be provided by the ALR on how to safely administer anti-hypertensive medications, when to assess residents, and when to notify physicians of a resident's change in

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R 292	Continued From page 3 status. At the time of the survey, LPN #1 failed to appropriately and adequately provide services to address Resident # 4's change in health status.	R 292	R393 1) The Abuse, Neglect, and Exploitation requirements was posted immediately. 2) Staff will be educated to include where the Abuse, Neglect, and Exploitation reporting requirements are posted. 3) During monthly rounds, the Abuse, Neglect, and exploitation reporting requirements will be checked to ensure that it is posted.	12/12/2018 01/31/2019 Ongoing
R 393	Sec. 509c Abuse, Neglect, and Exploitation. (c) An ALR shall post signs that set forth the reporting requirement of this section conspicuously in the employee and public areas of the ALR. Based on observation and interview, the ALR failed to post signs that set forth abuse, neglect, and exploitation reporting requirements in a conspicuous area for employees and the public. Findings included: Observation of the ALR on 12/12/18 starting at 10:00 AM showed there was no evidence of a posted sign in the facility that outlined the reporting requirements for an employee or anyone who believes a resident has been subjected to abuse, neglect, or exploitation. During an interview on 12/12/18 at 11:00 AM, the ALR Coordinator stated that the sign had been mistakenly taken down, but she would have it replaced. At the time of the survey, the ALR failed to post a sign that outlined reporting requirements for suspected abuse, neglect, or exploitation.	R 393		
R 472	Sec. 604a2 Individualized Service Plans (2) An ISP shall be developed following the completion of the "post move-in" assessment.	R 472		

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R 472	Continued From page 4 Based on record review and interview, the ALR failed to ensure an ISP had been developed after the post-move-in assessment for one of two newly admitted residents in the sample (Resident #3). Findings included: Review of Resident #3's clinical record on 12/13/18 at 11:30 AM showed that the resident was admitted on 08/17/18, at which time the ALR's nurse conducted a post-move-in assessment. Further review of the record revealed there was no documented evidence that an ISP had been developed following the resident's post-move-in assessment. During an interview on 12/12/18 starting at 11:50 AM, the Nurse Coordinator stated that she would ensure a post-move-in ISP is developed for all newly admitted residents. At the time of the survey, the ALR failed to ensure. Resident #3 had an ISP developed following the completion of the post-move-in assessment.	R 472	R472 1) Resident #3 was admitted 08/17/2018 and the post move-in ISP was developed on 10/23/2018. 2) Licensed nurses will be educated to include to initiate post move-in ISP during the post move-in assessment. 3) Post move-in ISPs will be monitored monthly x6 to ensure they are initiated during the post move-in assessment.	10/23/2018 01/31/2019 Ongoing
R 481	Sec. 604b Individualized Service Plans (b) The ISP shall include the services to be provided, when and how often the services will be provided, and how and by whom all services will be provided and accessed. Based on observation, interview and record review, the ALR failed to document in ISPs the services to be provided, when, and how often those services would be provided for three of five residents in the sample (Residents # 1, #3, and #5).	R 481		

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R 481	Continued From page 5 Findings included: 1. During an interview on 12/11/18 at 10:00 AM, the Nurse Coordinator revealed that Resident #1 received companion services. Review of Resident #1's current medical record on 12/11/18 at 1:30 PM showed ISPs dated 02/05/18 and 07/24/18 that documented the resident was receiving PDA services four hours a day to "assist in maintaining [resident's] care." The ISP failed to document what services were to be provided by the companion. Observation of Resident #1's apartment on 12/12/18 at 11:00 AM revealed a CNA who was helping the resident in the bathroom. The CNA stated that she provided help with ADLs and transferring the resident. During a second interview on 12/12/18 at 2:00 PM, the Nurse Coordinator stated that Resident #1 does not receive hands-on PDA services, but does receive companion services four hours a day, five days a week. The Nurse Coordinator also stated that the companion was off, so they had a CNA fill-in to help the resident on 12/12/18. 2. Review of Resident #3's clinical record on 12/13/18 at 11:30 AM showed a H&P dated 08/09/18 (not signed by the physician until 08/23/18), which indicated that the resident had a primary diagnosis of falls and behavior of wandering. Continued review of the record revealed ISPs dated 08/09/18 and 10/23/18 that lacked documented evidence of services to be provided to address the resident's diagnosis of falls and behavior of wandering. Further review of the record revealed the resident had a total of	R 481	R481 Finding 1 1) Resident #1 ISP for companion services will be completed to include what services are provided by the companion. 2) Licensed Nurses will be educated to include in the ISPs the services provided by the private duty and the companions. 3) The ISPs will be audited monthly x6 to ensure the services provided by the private duty and companions are in the ISPs. Finding 2 1) For Resident #3, the Physician will clarify the information on the H&P to include that resident #3 does not wander. Upon initial facility assessment, there were no findings of Resident #3 to have behavior of wandering. Documented evidence of services provided for falls will be added to Resident #3's Chart. 2) The licensed nurses will be educated to include that any active diagnosis identified in the H&P will be noted in the ISP for follow-up; and to update the ISPs to include services provided to address active diagnosis. 3) ISPs will audited monthly x6 to ensure that evidence of services are provided are in the ISP.	01/31/2019 01/31/2019 Ongoing 01/31/2019 01/31/2019 01/31/2019

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R 481	Continued From page 6 four falls on 08/27/18, 09/04/18, 11/13/18, and 11/15/18. The resident was sent to a local ER for evaluation after the most recent falls on 11/13/18 and 11/15/18. During an interview on 12/13/18 at 1:00 PM, the Nurse Coordinator stated that the resident does not wander, and she would follow-up with the resident's physician about the behavior of wandering indicated on the H&P. The Nurse Coordinator also stated that the resident was receiving therapy services to address falls. 3. Review of Resident #5's clinical record on 12/14/18 at 10:30 AM showed a H&P dated 02/27/18, which indicated that the resident had impulsive behaviors. Continued review of the record revealed ISPs dated 02/28/18, 04/11/18, 09/12/18, and 12/03/18 that lacked documented evidence of services to be provided to address the resident's impulsive behaviors. During an interview on 12/14/18 at 1:00 PM, the Nurse Coordinator stated that she would ensure the resident's ISP is updated to include services to address impulsive behaviors. At the time of the survey, the ALR failed to ensure that residents' ISPs included all services to be provided for Residents #1, #3, and #5.	R 481	R481 Finding 3 1) For Resident #5, the Physician will clarify the information on the H&P to include that resident #5 does not have impulsive behaviors. Upon initial facility assessment, there were no findings of Resident #5 to have impulsive behaviors. 2) The licensed nurses will be educated to include that any active diagnosis identified in the H&P will be noted in the ISP for follow-up; and to update the ISPs to include services provided to address active diagnosis. 3) ISPs will audited monthly x6 to ensure that evidence of services are provided are in the ISP.	01/31/2019 01/31/2019 Ongoing
R 483	Sec. 604d Individualized Service Plans (d) The ISP shall be reviewed 30 days after admission and at least every 6 months thereafter. The ISP shall be updated more frequently if there is a significant change in the resident's condition. The resident and, if necessary, the surrogate shall be invited to participate in each	R 483		

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R 483	Continued From page 7 reassessment. The review shall be conducted by an interdisciplinary team that includes the resident's healthcare practitioner, the resident, the resident's surrogate, if necessary, and the ALR. Based on record review and interview, the ALR failed to ensure residents' ISPs were reviewed by the resident, the resident surrogate, the IDT, and/or updated for a significant change for two of four current residents in the sample (Residents #4 and #5). Findings included: 1. Review of Resident #4's current clinical record on 12/13/18 at 1:00 PM showed an ISP dated 08/07/18, which lacked documented evidence that it was reviewed by the resident, the resident's surrogate, and the IDT. During an interview on 12/13/18 at 2:00 PM, the Nurse Coordinator stated that going forward she would ensure that all ISPs are reviewed by the resident, the resident's surrogate, and the IDT. 2. Review of Resident #5's current clinical record on 12/14/18 at 10:30 AM showed ISPs dated 04/11/18 and 12/03/18, which indicated that the resident was receiving physical and occupational therapy services. Further review of the ISPs lacked documented evidence that they had been reviewed by the PT and OT. Continued review of the record showed that Resident #5 sustained a right hip fracture following a fall while at a family member's home on 06/15/18. The record, however, lacked documented evidence that the ISP had been updated to reflect this significant change. During an interview on 12/13/18 at 1:00 PM, the	R 483	R483 Finding 1 1) The ISP for Resident #4 that was dated for 08/07/18 was not completed and reviewed by the resident and the IDT team until 11/13/2018. Evidence of the review is reflected via signature. Resident is alert and oriented and does not want her surrogate to review the ISP. 2) IDT will be educated to include that the ISPs are to be reviewed by the resident, resident's surrogate, and the IDT. 3) ISPs will be audited monthly x6 to ensure the ISPs are reviewed by the resident, the resident's surrogate, and the IDT. Finding #2 1) The ISP for Resident # 5 will be updated to include the significant change of the right hip fracture. 2) Licensed nurses will be educated to update the ISP when there is a significant change. IDT will be educated to include that the ISPs are to be reviewed by the resident, resident's surrogate, the IDT to include relevant Rehab Services to contribute as needed. 3) ISPs will be audited monthly x6 to ensure that significant changes are documented and to ensure that ISPs are reviewed by the resident, the resident's family, and the IDT.	11/13/2018 01/31/2019 Ongoing 01/31/2019 01/31/2019 Ongoing

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R 483	Continued From page 8 Director of Rehabilitation Services stated that the PT and OT do not review ISPs. At the time of the survey, the ALR failed to ensure the ISPs were reviewed by the resident, resident's surrogate, or the IDT.	R 483	R1003 1) The hot water supply was adjusted immediately to ensure that apartment #383 and #387 water temperature does not exceed 110 degrees Fahrenheit. All apartments in T3 were checked to ensure that the water temperatures in the apartments did not exceed 110 degrees Fahrenheit. 2) Engineers will be educated to include that water temperature to not exceed 110 degrees Fahrenheit. 3) Water temperature checks will be performed in 10% of residents' apartments weekly x6 and then biweekly to ensure to ensure that water temperatures do not exceed 110 degrees Fahrenheit. This will be evident by documentation in a log that the Engineer Director or designee will review monthly.	12/11/2018 01/31/2019 Ongoing
R1003	Sec. 1006c Bathrooms. (c) An ALR shall insure that the temperature of the hot water at all taps to which residents have access is controlled by the use of thermostatically controlled mixing valves or by other means, including control at the source, so that the water temperature does not exceed 110 degrees Fahrenheit. Based on observation and interview, the ALR failed to ensure that the hot water temperature did not exceed 110 degrees F in two of the 13 bathrooms inspected (Apartments #T383 and #T387). Findings included: During the environmental inspection on 12/11/18 at 10:53 AM, the hot water temperature measured 115 degrees F at the hand sink in the bathroom of Apartment #T383 and 115.6 degrees F in Apartment #T387. During an interview on 12/11/18 at 11:10 AM, the Director of Engineering stated that he would be able to lower the water temperatures for both apartments because individual water valves were located under the sinks in each apartment. Follow-up observations on 12/12/18 at 1:46 PM showed that the hot water temperatures at the hand sinks in apartments #T383 and #T387 were	R1003		

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R1003	Continued From page 9 between 103.9 and 105.5 degrees F. At the time of the survey, the ALR failed to ensure the water temperatures did not exceed 110 degrees F at all times.	R1003	R1091 1) On 12/14/2018 the Sunkist juice dispenser was cleaned immediately and the Sunkist juice that was in use was removed.	12/14/2018
R1032	Sec. 1009 2 Kitchen. (2) Food preparation areas with cleanable surfaces; Based on observation and interview, the ALR failed to ensure food preparation surface areas were maintained in a clean, sanitary condition. Findings included: During an environmental inspection of the ALR's kitchen on 12/14/18 at 2:06 PM, a Sunkist juice dispenser was observed with yellow and brown stains in each juice spout. Continued observation also showed that the juice, when dispensed, collected and dried in each individual spout. During an interview on 12/14/18 at 12:20 PM, the Operations Manager stated that he would clean the Sunkist juice dispenser immediately.	R1032	2) The Kitchen Staff was educated on 12/21/2018 to include how to clean the Sunkist juice dispenser. 3) The Sunkist juice dispenser will be cleaned by the dining staff and will be documented in a log daily. The cleaning of the Sunkist juice dispenser will be checked and signed off weekly in the log by the Dining Manager or designee.	12/18/2018 Ongoing