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	525717	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI VETERANS HM MACARTHUR 422	N2665 CTY RD QQ KING, WI 54946

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F 000	INITIAL COMMENTS This was a recertification, complaint, and self-report investigation survey conducted at Wisconsin Veterans Home - MacArthur Hall from 12/6/16 to 12/8/16. # of federal citations issued: 7 The most serious citations was F 164 cited at a scope/severity level of E (pattern/no actual harm with potential for more than minimal harm). Census: 112 Sample size: 23 Supplemental sample size: 4 Survey coordinator: 36402	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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); 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); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		

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

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and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interviews, the facility did not ensure the physicians of 2 members (M) (M13 and M7) of 20 members received prompt notification when there was a change in condition or when the member requested notification of the physician.
M13 experienced a fall on 11/28/16. M13 complained to RN-(Registered Nurse)-G of unresolved, persistent pain in the knee on Saturday, 12/3/16, requesting an x-ray. RN-G did not immediately notify the MD (Medical Doctor), other staff, or document the member's request in the medical record. On Tuesday, 12/6/16, M13 approached a second staff member regarding the pain and request for an x-ray. Staff addressed M13's concern at this time; the MD was notified and an x-ray was performed, three days after the initial report.
M7 complained of difficulty swallowing while taking some larger supplement capsules and tablets. On Monday, 12/5/16, M7 discussed swallowing concerns with RN-G, who indicated the physician would be contacted and the supplements discontinued. The physician was

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not contacted and M7 was strongly encouraged to take the supplements on 12/6/16, 12/7/16 and 12/8/16, despite the member's request to have them discontinued.
Findings include:
1. On 12/7/16 at 10:30 a.m., S (Surveyor) 26437 interviewed M13 for a routine Quality of Life Assessment. M13 shared a concern about the facility's lack of follow through with regard to a fall. M13 indicated a history of a knee replacement several years before and on 11/28/16 experienced a fall. M13 stated member was still experiencing pain 5 days later, especially in the area of the knee replacement. On Saturday, 12/3/16 M13 approached RN-G to complain of the persistent pain and request an x-ray of the area. M13 indicated RN-G said, "I have worked in the ER (Emergency Room) for many years and never heard of a knee replacement being injured after a fall." M13 expected the RN to notify the MD and obtain an order for an x-ray so, "I waited all day Monday (12/5/16) for an x-ray which did not happen." M13 notified a second RN Tuesday (12/6/16) of the same concern and request which was then addressed. M13 stated, "This is why I don't trust them (facility staff), I was mad as a wet hen (RN-G) did not follow through."
On 12/6/16 S26437 reviewed the medical record of M13. The 7/27/16 face sheet contained within the medical record indicated M13 was admitted with diagnoses to include: chronic kidney disease, sciatica, diabetes, chronic obstructive pulmonary disease, macular degeneration, hypertension, and a lung mass. The most recent quarterly MDS (Minimum Data Set) assessment, dated 10/25/16, indicated M13 scored 15 of 15 on the BIMS (Brief Interview for Mental Status) indicating no cognitive impairment or memory loss.

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A "Fall Incident Report" dated 11/26/16, indicated M13 experienced a witnessed fall on 11/28/16 at 4:55 p.m. The report indicated the "on-call" physician was notified of the fall at 5:15 p.m. The first shift after the fall, staff reported a "bruise to right knee."

A review of nurses notes from 12/3/16 through 12/5/16, show no indication M13 complained of knee pain or requested an x-ray. A telephone order dated 12/6/16 documented, "X-ray right knee related to pain/fall."

On 12/7/16 at 1:00 p.m., S26437 spoke to RN-G who verified "M13 notified me over the weekend sometime that (M13's) knee was still hurting after the fall, yes, it was Saturday (12/3/16)." RN-G indicated M13 was walking around without difficulty and did not call the MD "because it was the weekend." RN-G verified there was 24-hour "MD on-call coverage." RN-G further verified she did not document the member's persistent pain complaint and x-ray request. RN-G indicated she assessed M13's knee, "There was nothing there, (M13) was walking fine." RN-G confirmed she told M13 she worked in the ER.

2. On 12/6/16 at 8:42 a.m., S26437 observed medications passed to M7 by LPN (Licensed Practical Nurse)-K. The medications were crushed and as they were handed to M7, the member stated, "All my supplements were discontinued yesterday (Monday 12/5/16), I talked to RN-G, I don't have to take the supplements." M7 indicated the supplements made the member gag and vomit was they were difficult to swallow. LPN-K volunteered at that time, "The MAR (Medication Administration Record) indicates they were not discontinued, I will talk to the nurse." LPN-K held the medications and spoke to the charge nurse.

On 12/6/16 at 9:00 a.m., charge nurse, RN-L,

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reported to S26437 there was no documentation in the medical record that M7 requested to discontinue the supplements. RN-L stated there was no order to discontinue the supplements, but that M7 had repeated the same details; the supplements were to be discontinued after RN-G spoke to the MD. RN-L indicated M7 was encouraged to take the morning medications per MD order.

On 12/6/16 at 9:20 a.m., S26437 observed LPN-K re-approach M7 with the medications. M7 stated, "Just give me the crap, I don't know why I have to take them, I gag and vomit, just talk to RN-G." LPN-K encouraged M7 to take the medications stating, "The doctor ordered them." As the medications were being consumed by M7, the member began gagging.

On 12/6/16 S26437 reviewed the medical record of M7. The 7/27/16 face sheet contained within the medical record documented the following admitting diagnoses: chronic obstructive pulmonary disease, hypokalemia, macrocytosis with anemia, restless leg syndrome, hyperlipidemia, alcoholism. The most recent quarterly MDS dated 10/19/16 documented M7 scored 15 of 15 on the BIMS.

A physician's visit note dated 8/12/16 documented: "Probably the biggest concern is a cyst that (M7) has in (the member's) ear to throat...there are several entries into the chart for the left mass biopsy, as well as just a left mass procedure in general. Unfortunately, it is a bronchial cleft cyst and a biopsy was aborted due to the extensiveness of the cyst; that was done by ENT otolaryngology in 4/16...(M7) is well aware that the cyst exists and it appears inoperable at this point...problems related to (the member's) inability to swallow."

On 12/7/16 at 1:10 p.m., S26437 interviewed

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F 157	Continued From page 5 RN-G who stated "I overheard M7 talk to the LPN, I know of (M7's) request...I did not follow through with a call to the physician, I was going to do that after I came back next Sunday (12/11/16), I will talk to (M7) again." RN-G indicated she last worked on 12/6/16 and was off work until 12/11/16. It was also verified RN-G did not pass along the member's concern to other staff for follow up. On 12/8/16 at 8:20 a.m., S26437 approached LPN-K who verified, "RN-G must not have talked to the MD, I will talk to the other RN today to see if we can get them (supplements) discontinued." On 12/8/16 at 8:45 a.m., S26437 interviewed M7 who again verified, "I talked to RN-G on Monday who said I didn't have to take them (the supplements), but that she would talk to the MD. I have a hard time swallowing, a cyst is growing up in my throat. I'm mad they are still making me take them." On 12/8/16 at 9:15 a.m., S26437 interviewed LPN-J who verified she worked and passed medications to M7 on Monday, 12/5/16. "I was standing with M7 when (the member) told RN-G, "I can't swallow my pills, I don't want to take all my supplements." LPN-J indicated the conversation was directed to RN-G who told the member the MD would be contacted so the supplements could be discontinued. On 12/8/16, S26437 again reviewed the medical record of M7. There was no documentation in nurses notes or correspondence to the MD regarding M7's request to discontinue the supplements on 12/6/16, 12/7/16 or 12/8/16.	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and	F 164		

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confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

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.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility did not provide privacy for 4 of 4 Members (M) (M24, M25, M26, and M27) who resided on Unit 2, Section B of the facility.
Unit 2, Section B had an operating motion sensor video camera installed in the ceiling at the end of the hallway which was capable of filming people entering/exiting member rooms.
Finding include:

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The facility policy, entitled "Security Cameras", with a revision date of November 2016, states: "...Security cameras on the WVH-King campus are located in the Marston parking lot; MacArthur Hall Pharmacy Office; the Stordock Hall Community First Credit Union Office; the IT Server Room in Ainsworth Hall; the front entrances, first floor lobbies and basement lobbies of the nursing care buildings (AH, MH, OH, SH); Marden Memorial Center first floor, throughout the basement to include Alley Five, pool room, KX, Veterans Cafe and the boat dock just outside of the Cafe; the front entrance and back loading dock of the central services building; multiple locations throughout the tunnel leading to all buildings that have tunnel access; and the band stand in the park. ...Security cameras cannot be used in private areas such as member rooms, bathrooms shower areas, changing rooms, rooms used for medical, physical or mental therapy or treatments ..."

On 12/7/16 at 1:30p.m., Surveyor 36777 conducted the group interview. During the group interview, M25 mentioned a video camera was installed on Unit 2, Section B due to a member alleging someone was stealing money out of the member's room.

On 12/8/16 at 8:00a.m., Surveyor 36777 observed a video camera in the ceiling of Unit 2, Section B. There are four member rooms, a stairwell and bathroom, located within 15-20 feet of the video camera.

On 12/8/16 at 12:30p.m., Surveyor 36777 interviewed NHA (Nursing Home Administrator) A and SS (Security Supervisor) B regarding the video camera. NHA A stated the camera was set up about two years ago because of a member making allegations about stolen property out of the member's room. The member continues to

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F 164	Continued From page 8 reside on Section B, however, the member has not had any recents complaints about stolen property. SS B stated the video camera is a motion sensor camera with a sensor range of 15-20 feet. The video feed is only accessed if there is an allegation of stolen property, and the video would help substantiate the allegation. NHA A stated members are made aware of the video camera through the facility's surveillance policy.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and member interview, the facility did not ensure that 1 Member (M) (M20) of 20 sampled members, was assessed to safely self-administer medications. M20 had a self-administration assessment which indicated "Member requires supervision to take medications prepared by the licensed nurse." M20 was observed alone in the bedroom with a full cup of medications. Staff had distributed the medications and left the room without supervising their administration. Findings include: On 12/7/16 S (Surveyor) 26437 reviewed the	F 176		

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EMR (Electronic Medical Record) of M20. The 2/5/16 facesheet contained within the medical record documented the following admitting diagnoses: heart failure, left thigh pain, muscle weakness, peptic ulcer, chronic kidney disease, hypertension, anemia and anxiety. The most recent quarterly MDS (Minimum Data Set) assessment dated 9/27/16 indicated the member scored 15 of 15 on the BIMS (Brief Interview Mental Status) which indicated no cognitive impairment or memory loss. The 6/16/16 "Assessment for Self Administration of Medication" for M20 indicated, "Member requires supervision to take medications prepared by a licensed nurse."

On 12/18/16 at 10:08 a.m., S26437 approached M20's room to conduct the routine Quality of Life interview. M20 indicated the member was busy in the bathroom. S26437 waited outside the member's door until permission was granted. During that approximate 5 minute wait, no staff entered or exited the member's room. Upon entrance to the room, S26437 observed a medication cup on the overbed table, filled with capsules and tablets. M20 verified they were the morning medications, "The nurse left them because I was going to the bathroom." S26437 then attempted to locate the nurse who distributed M20's medications. Staff indicated the nurse was off the unit taking a lunch break.

On 12/8/16 at 11:25 a.m., S26437 interviewed LPN (Licensed Practical Nurse)-M who verified she left M20's pills on the overbed table, "(M20) can take them unsupervised, when I went back they were gone." LPN-M then verified to S26437 that M20's medical record indicated the member needed supervision with medication

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F 176	Continued From page 10 administration. On 12/8/16 at 11:30 a.m., S26437 interviewed charge nurse, RN (Registered Nurse)-P who verified the medical record and self-administration assessment indicated M20 required supervision and the medications should not be left in the member room without watching the member take them.	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and member interview, the facility did not ensure 1 Member (M) (M7) of 20 sampled members was able to make choices about health care, consistent with their own assessments and plans of care. M7 had difficulty swallowing and requested discontinuation of dietary supplements from the medication regimen that were causing the member to gag and vomit. Staff did not contact the MD (Medical Doctor) to discontinue the supplements. Additionally, staff strongly encouraged M7 to take the medications without facilitating the member's right to refuse.	F 242		

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Findings include:

On 12/6/16 at 8:42 a.m., S26437 observed medications passed to M7 by LPN (Licensed Practical Nurse)-K. The medications were crushed and as they were handed to M7, the member stated, "All my supplements were discontinued yesterday (Monday 12/5/16), I talked to RN-G, I don't have to take the supplements." M7 indicated the supplements made the member gag and vomit was they were difficult to swallow. LPN-K volunteered at that time, "The MAR (Medication Administration Record) indicates they were not discontinued, I will talk to the nurse." LPN-K held the medications and spoke to the charge nurse.
On 12/6/16 at 9:00 a.m., charge nurse, RN-L, reported to S26437 there was no documentation in the medical record that M7 requested to discontinue the supplements. RN-L stated there was no order to discontinue the supplements, but that M7 had repeated the same details; the supplements were to be discontinued after RN-G spoke to the MD. RN-L indicated M7 was encouraged to take the morning medications per MD order.
On 12/6/16 at 9:20 a.m., S26437 observed LPN-K re-approach M7 with the medications. M7 stated, "Just give me the crap, I don't know why I have to take them, I gag and vomit, just talk to RN-G." LPN-K encouraged M7 to take the medications stating, "The doctor ordered them." As the medications were being consumed by M7, the member began gagging.
On 12/6/16 S26437 reviewed the medical record of M7. The 7/27/16 face sheet contained within the medical record documented the following admitting diagnoses: chronic obstructive

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pulmonary disease, hypokalemia, macrocytosis with anemia, restless leg syndrome, hyperlipidemia, alcoholism. The most recent quarterly MDS dated 10/19/16 documented M7 scored 15 of 15 on the BIMS.

A physician's visit note dated 8/12/16 documented: "Probably the biggest concern is a cyst that (M7) has in (the member's) ear to throat...there are several entries into the chart for the left mass biopsy, as well as just a left mass procedure in general. Unfortunately, it is a bronchial cleft cyst and a biopsy was aborted due to the extensiveness of the cyst; that was done by ENT otolaryngology in 4/16...(M7) is well aware that the cyst exists and it appears inoperable at this point...problems related to (the member's) inability to swallow."

On 12/7/16 at 1:10 p.m., S26437 interviewed RN-G who stated "I overheard M7 talk to the LPN, I know of (M7's) request...I did not follow through with a call to the physician, I was going to do that after I came back next Sunday (12/11/16), I will talk to (M7) again." RN-G indicated she last worked on 12/6/16 and was off work until 12/11/16. It was also verified RN-G did not pass along the member's concern to other staff for follow up.

On 12/8/16 at 8:20 a.m., S26437 approached LPN-K who verified, "RN-G must not have talked to the MD, I will talk to the other RN today to see if we can get them (supplements) discontinued."

On 12/8/16 at 8:45 a.m., S26437 interviewed M7 who again verified, "I talked to RN-G on Monday who said I didn't have to take them (the supplements), but that she would talk to the MD. I have a hard time swallowing, a cyst is growing up in my throat. I'm mad they are still making me take them."

On 12/8/16 at 9:15 a.m., S26437 interviewed

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F 242	Continued From page 13 LPN-J who verified she worked and passed medications to M7 on Monday, 12/5/16. "I was standing with M7 when (the member) told RN-G, "I can't swallow my pills, I don't want to take all my supplements." LPN-J indicated the conversation was directed to RN-G who told the member the MD would be contacted so the supplements could be discontinued. On 12/8/16, S26437 again reviewed the medical record of M7. There was no documentation in nurses notes or correspondence to the MD regarding M7's request to discontinue the supplements on 12/6/16, 12/7/16 or 12/8/16.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility did not provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well being of 1 Member (M) (M7), of 20 sampled members. M7 had a diagnosis of alcoholism. Staff were aware and documented M7 continued to drink alcohol regularly. Staff did not assess or monitor the frequency and/or effects of alcohol consumption for M7. Staff did not develop a plan of care to address alcohol related treatment	F 250		

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and/or substance abuse.

Findings include:

The State of Wisconsin Department of Health Services published the following regarding Substance Abuse Services last revised 8/266/16..
"The Administrative Code, DHS 75, states that Substance Abuse treatment service providers make recommendations for initial placement, continued stay, level of care transfer and discharge of a patient. One tool the code recognizes for this purpose is the Wisconsin Uniform Placement Criteria (WI-UPC)...WI-UPC is a rationally-based response to managed health care planning, because it is clinically focused and represents a "best practice" standard produced through a consensus-building effort within the substance abuse treatment delivery system.
Benefits of adopting WI-UPC include the following clinical and systems improvements:
Pursuit of quality care with an individualized focus;
Multidimensional treatment planning;
Treatment based upon a cost effective approach;
Routine process for evaluating treatment outcomes and program planning;
Recognition of the need for a seamless system of care, ranging from outpatient to residential, and encourages the development of this continuum;
Provides benchmarks and the foundation for patients, providers and payers to gauge the appropriateness of a level of treatment, monitor progress and identify expected outcomes.
...It is expected that providers will have the ability and creativity to develop individualized treatment plans to meet needs by modifying the levels of care that are available or by working collaboratively with other treatment providers

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within the community or geographic area.
...Liability remains the same as with any clinical decision for both provider and payer. Providers must make treatment decisions based on their assessment of the clinical presentation of the individual. The WI-UPC criteria has been established to place individuals at the most appropriate, least restrictive level of care. Appropriate application of the criteria should ensure proper placement.
...While it is necessary to offer the individual information on the available options, it is important for the counselor to make every effort to initiate the referral for the individual as soon as possible.
...A substance abuse screening of the patient must be completed in order to obtain the necessary information to adequately respond to the seven qualifying criteria and the five dimension questions in WI-UPC. Any screening instrument may be used as long as it examines each of these areas...Information from the substance abuse screen is applied to the seven qualifying criteria. If the response to ANY of the qualifying questions is "Yes", the patient is determined to be in possible need of referral to some level of formal substance abuse treatment services, and the remaining four dimensions should be evaluated. If the response to ALL of the qualifying questions is "No", the patient is determined to not be in need of services in the formal treatment delivery system. If the need for formal services is not identified, it is important to determine whether the patient should be referred to informal community support groups, other community resources or to a service delivery system other than substance abuse treatment..."

On 12/6/16 S (Surveyor) 26437 reviewed the

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medical record of M7. The 7/27/16 face sheet contained within the medical record documented the following admitting diagnoses: chronic obstructive pulmonary disease, hypokalemia, macrocytosis with anemia, restless leg syndrome, hyperlipidemia, history of embolism and alcoholism. The most recent quarterly MDS (Minimum Data Set) dated 10/19/16 documented M7 scored 15 of 15 on the BIMS (Brief Interview for Mental Status) indicating no cognitive impairment.
Care conference notes dated 8/24/16 documented, "M7 continues with drinking, recent fall related to alcohol...(M7) does not see a problem with (the member's) drinking...
Care conference notes dated 3/16/16 documented, "Continues to drink alcohol on a regular basis...aware of the rules but continues to drink despite risks. Warfarin (blood thinning medication) discontinued secondary to drinking."
A doctor's statement of incapacity, signed 6/20/13 declared, "M7 incapacitated, activating the POAHC (Power of Attorney for Health Care).

Physician's visit notes dated 11/11/16, 10/18/16, 9/27/16 and 8/12/16 did not address M7's alcoholism.

The written plan of care for M7, most recently updated 10/4/16, documented: "I am at risk for an alteration in thought process and ineffective coping related to my cognitive losses, depression, alcoholic liver disease." The only intervention for staff: "Know that I have a history of having alcohol in my room. If you suspect that I have been drinking, talk to me and see if I have been drinking. I used to drink alcohol daily when I lived at home. Report to the RN (Registered Nurse) and SW (Social Worker) if you feel I have alcohol

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in my room."

SW progress notes dated 12/22/15 indicated, "I also found 1 empty 1.75 liter bottle of vodka...2 empty 750 ml bottles of vodka, 2 1/4 full 750 ml bottles of vodka and 1 full 750 ml bottle of vodka. One small one hit rum was also found...I talked to (M7) about (the member's) taxi pass and how it is unsafe for (the member) to be buying alcohol for other members and also hiding it in (the member's) room..."

SW progress note dated 2/15/16, indicated, "(M7) declined to see the LCSW (Licensed clinical Social Worker) at this time...does not want to stop drinking at this time."

SW progress note dated 3/8/16, indicated, "I will continue to see M7 as needed and ask permission to check room in the future if there is a need..."

A Fall Investigation report dated 8/22/16 indicated M7, "Had a few drinks today...fell "outdoors next to the Chain Bar..." The fall follow-up dated 8/23/16 documented, "Continue to monitor alcohol consumption."

SW progress notes dated 8/24/16 indicated, "(M7) had a fall in the past week...was coming back from the Chain Bar...admitted to drinking... I talked with (M7) about being more careful and to be careful with how much (M7) drinks."

SW progress notes dated 9/30/16 indicated, "(M7's)...room was checked by myself and 2 CNA (Certified Nursing Assistants) to check for alcohol...(M7) Currently in the hospital and the doctor was concerned that (M7) could be

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withdrawing from alcohol which prompted the room search..."

SW progress notes dated 10/3/16 indicated, "(M7) was requesting to have a drink this morning. The RN checked with the doctor...the doctor said no to M7 having an order for alcohol on the unit..."

SW progress notes dated 11/16/16 indicated, "I spoke to...POAHC...of M7. I updated her on the last time alcohol was removed from (M7)'s room (9/30/16)...(POAHC) aware that M7 goes to Chain Bar for lunch and a drink..."

On 12/7/16 at 2:00 p.m., S26437 interviewed SW-H about M7's substance abuse. SW-H confirmed that with the member's permission, room sweeps have been conducted and SW-H has found "a lot" of alcohol. M7 had a taxi pass taken away for a time but it has been reinstated, so the member can go out independently to purchase and consume alcohol. Regarding risks and benefits, SW-H indicated that a MD should discuss risks with the member, not SW. SW-H verified there was no plan for regular room sweeps, no plan to assess for intoxication or withdrawal symptoms or what assessments should be made when the directive is "Continue to monitor." SW-H confirmed the facility did not conduct alcohol assessments. Additionally, there has been no plan of care to assess the member's safety if and when the member became intoxicated or what, if any, side effects or consequences could occur from the mixing of alcohol with any of the member's medications.

On 12/8/16 at 1:30 p.m., S26437 interviewed LCSW (licensed Clinical Social Worker)-I who

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F 250	Continued From page 19 verified he was also a CSAC (Certified Substance Abuse Counselor.) LCSW-I stated he was unfamiliar with the State's UPC or it's assessment tool because he has only lived and practiced in this state for five years. LCSW-I confirmed he had visited with M7 about six times and that all of the visits were "talk therapy." LCSW-I verified he had never conducted an alcohol assessment for M7, did not initiate treatment referral, was not routinely involved in care planning and did not identify measurable treatment goals for M7. LCSW-I indicated M7 was resistant to talk therapy and refused to talk about alcohol consumption. "(M7) has agitated anger issues and drinks daily." When asked what options could be utilized if a patient was a danger to themselves while under the facility's care, LCSW-I agreed in-patient treatment options and utilizing a county referral and law enforcement were all possible. LCSW indicated the members had a right to drink if they wanted to and, "We can't stop them." LCSW stated he was very involved in the 12 step program on the Vets campus and AA meetings were held 3 times a week with three to four members participating. M7 did not participate in the treatment modality offered.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		

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assessment.

The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility did not develop a comprehensive plan of care for 2 Members (M) (M2 and M1) of 20 sampled members.
M2 was known to make sexual comments towards staff. The facility did not develop a plan of care to address the sexual comments.
M1 shared with multiple staff members being upset that M1 was not own decision maker and POAHC (Power of Attorney for Health Care) had been activated. In addition, M1's physician assessed member three times and declined to deactivate M1's POAHC. The facility did not develop a plan of care to address M1's difficultly coping with feelings of anger related to the activation of the POAHC and diagnosis of dementia.
Findings include:
On 12/7/16 at 12:15 p.m., Surveyor 36777 reviewed the medical record for M2. The behavior mood assessments completed on 11/16/16 and 11/25/16, indicate M2 made sexual comments or gestures to staff. In a note from the Nurse Practitioner (NP) on 11/18/16, the NP was

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made aware M2 was making sexual comments to staff. Additionally, progress notes dated 12/2/16 and 12/6/16 state M2 had made sexual comments to a CNA (Certified Nursing Assistant) and activity staff member, respectively.

On 12/7/16 at 1:15 p.m., Surveyor 36777 interviewed SW (Social Worker) C regarding the care plan for R2. SW C stated M2 may have made some sexual comments to staff but was redirected. SW C stated she hasn't had staff come to her with consistent statements about M2's sexual comments. SW C stated she would not be responsible to update M2's care plan regarding sexual behaviors. SW C stated maybe nursing would update M2's care plan.

On 12/8/16 at 8:45 a.m., Surveyor 36777 interviewed RN (Registered Nurse) D regarding the care plan for M2. RN D was not aware of M2's sexual comments. RN D checked M2's care plan and verified nothing was listed about the sexual comments. RN D stated she would talk with the social worker regarding the issue.

On 12/8/16 at 10:20 a.m., Surveyor 36777 interviewed ADON (Assistant Director of Nursing) E regarding M2's sexual comments. ADON E stated staff had updated the care plan which shows M2's sexual behavior was assessed and care planned. ADON E was unsure when the care plan was updated. ADON E suggested Surveyor 36777 talk to MDS (Minimum Data System) Coordinator F to find out when the care plan was updated.

On 12/8/16 at 10:25 a.m., Surveyor 36777 interviewed MDS F. MDS F verified the care plan was updated on 12/8/16 along with the CNA

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(Certified Nursing Assistant) kardex.

2. According to M1's face sheet dated 7/27/16, M1 had a diagnosis of vascular dementia.

M1's POAHC was activated prior to admission to the facility on 8/13/16. It was noted on M1's POAHC activation paperwork M1 maintained the ability to choose an agent and/or surrogate agent.

M1's Annual MDS (Minimum Data Set) dated 10/18/16, documented a score of 15/15 on the BIMS (Brief Interview for Mental Status). The higher the score the more cognitively intact the resident.

A SLUMS (The Saint Louis University Mental Status Exam), an oral and written exam used to for people with suspected dementia or Alzheimer's Disease dated 8/4/16, documented M1 scored 23 (21-26)/30 indicating mild neurocognitive dementia.

On 12/7/16 at 9:15 a.m., S14108 interviewed M1. M1 indicated wanting to be own decision maker, but daughter was decision maker because the POAHC was activated. M1 disagreed with daughter being the agent and wanted member's brother to be the agent. When asked if M1 spoke with the social worker or someone at the facility, M1 stated yes and that M1 saw the psychologist, but would not reverse it (deactivate the POAHC). S14108 explained to M1 that M1 could void the POAHC document, but then the facility may have to petition for guardianship. M1 told S14108 that M1 did not want this to happen and to keep the POAHC in place. When asked, M1 did verify M1 was involved in making decisions. M1 expressed anger and disagreement with both the activated

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POAHC and any diagnosis of dementia indicating M1 was unable to be her own decision maker.

On 12/7/16, S14108 reviewed M1's medical record and the record did not contain a care plan addressing M1's feeling of anger, difficulty accepting the activated POAHC and any diagnosis of dementia.

A Care Conference Note dated 2/1/16, documented M1 was upset regarding the psychologist evaluating M1 again and deciding not to deactivate M1's POAHC. The facility did not develop a care plan to address M1's difficulty accepting and/or member's feelings of anger regarding diagnosis of dementia and needing POAHC activated to involve POAHC agent in making health care decisions.

A psychological note dated 5/25/16, documented M1 declined scheduled appointment and told nursing staff M1 no longer wanted psychological services.

A physician's note dated 8/9/16, documented M1 has an activated POAHC which M1 does not appreciate. M1 is being re-evaluated for a possible reversal (deactivation) of the POAHC.

A Care Conference Note dated 8/9/16, documented M1 talking about reversing incompetence evaluation again (deactivating POAHC document).

A physician's note dated 9/8/16, documented M1 was moved to the second floor. The note referenced M1's POAHC document which M1 would like changed. The note also indicated to do what M1 needs; a different POAHC. M1

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expressed that daughter (POAHC agent) is not managing member well.

A social services note dated 9/6/16, documented SW C and NHA (Nursing Home Administrator) A met with M1 and explained M1 must have a decision maker for healthcare. Staff discussed the results of the third evaluation to deactivate the POAHC. The note documented M1 became tearful and indicated M1 understood why member still needed a decision maker. Staff did not develop a care plan to address M1's difficulties accepting the activated POAHC or the diagnosis of dementia.

On 10/18/16, MDS N documented a Late Entry regarding a meeting with M1 for M1's Annual MDS interview. MDS N documented M1's diagnoses of vascular dementia, and that MDS N explained to M1 what dementia was, but M1 was adamant that (M1) doesn't have "any of it." M1 expressed how much she disliked her physician and that she told him he was wrong. R1 also stated not liking and refusal to speak with the psychologist any longer because psychologist will not reverse M1's competency (incapacity).

On 12/8/16 at 10:43 a.m., S14108 interviewed MDS N regarding her interview with M1 documented on 10/18/16. MDS N verified M1 was upset regarding the POAHC not being deactivated, and M1's difficulty accepting the diagnosis of dementia. When asked who would be responsible for developing a care plan to address these issues, MDS N indicated the social worker would be responsible to develop the care plan. MDS N indicated she could not recall if she spoke with the social worker following her conversation with M1 and the issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A physician's note dated 11/1/16, documents M1 being upset about the POAHC being enacted (activated), but M1 has not been able to fulfill objective criteria to allow the POAHC deactivated. Plan: Discuss care plan with nursing staff, social work and patient.

On 12/7/16 at 12:50 p.m., S14108 interviewed SW C regarding M1 and M1's medical record. SW C indicated she did ask M1's brother if he would consider being M1's POAHC agent, but he declined because he did not want any family arguments. SW C when asked, did indicate she explained to M1 that M1 could fire her POAHC agent, but then the facility would have to petition for guardianship which would have to be paid for. SW C indicated M1 told staff M1 would keep the POAHC as it was. SW C verified she had not documented these discussions with M1 in M1's medical record.

On 12/8/16 at 11:00 a.m., S14108 interviewed SW C regarding M1. SW C verified she did not develop a care plan to address M1's difficulty dealing and/or feelings of anger with her diagnosis of dementia and the need for an activated POAHC.

The facility did not develop a care plan to address M1's difficulty accepting and/or her feelings of anger regarding the diagnosis of dementia, and needing the POAHC activated despite M1's continued complaints and difficulty dealing with diagnosis of dementia and activated POAHC.

On 12/8/16 at 11:30 a.m., S14108 met with ADON (Assistant Director of Nursing) E, DON (Director of Nursing) O and NHA (Nursing Home

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	525717	A. BUILDING _____ B. WING _____	12/08/2016

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F 279	Continued From page 26 Administrator) A regarding M1. Staff agreed a care plan should have been developed to address M1's above issues.	F 279		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility did not maintain 1 Member's(M) (M1) record out of 23 sampled member clinical records in accordance with accepted professional standards and practices that are complete and accurately documented. M1 repeatedly complained and expressed feelings of anger about member's POAHC (Power of Attorney for Health Care) needing to be activated related to M1's diagnosis of dementia, and the facility did not completely and accurately document staff interventions and conversations with M1.	F 514		

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Findings include:

M1's POAHC was activated prior to admission to the facility on 8/13/16. It was noted on M1's POAHC activation paperwork M1 maintained the ability to choose an agent and/or surrogate agent.

M1's Annual MDS (Minimum Data Set) dated 10/18/16, documented a score of 15/15 on the BIMS (Brief Interview for Mental Status). The higher the score the more cognitively intact the resident.

On 12/7/16 at 9:15 a.m., Surveyor(S)14108 interviewed M1. M1 indicated wanting to be own decision maker, but M1's daughter was decision maker because POAHC was activated. M1 disagreed with daughter being the agent and wanted brother to be the agent. When asked if member spoke with the social worker or someone at the facility, M1 stated yes and that member saw the psychologist, who would not reverse it (deactivate the POAHC). S14108 explained to M1 member could void the POAHC document, but then the facility may have to petition for guardianship. M1 told S14108 that M1 did not want this to happen and to keep the POAHC in place. When asked, M1 did verify M1 was involved in making decisions.

On 12/7/16 S 14108 reviewed M1's medical record. M1's medical record did not document that member wanted brother to be the POAHC agent, nor did the social service notes document M1's complaints regarding the activation of the POAHC and feelings of anger regarding the diagnosis of dementia. M1's medical record did not document any discussions with M1 regarding completing a new POAHC document to name the

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brother as agent or voiding the current POAHC document. M1's medical record did not document any discussions with M1's brother about becoming M1's agent and, if not an explanation of what would happen if M1 voided the current POAHC document. M1's medical record did have documentation of continued disagreement and anger over the activated POAHC and that M1 disagreed with any diagnosis of dementia.

The last documented note on M1's Advanced Directives Document dated 2/18/15, documented M1 completed a POA for Finances and named the brother as agent.

A Care Conference Note dated 2/1/16, documented M1 was upset regarding the psychologist evaluating M1 again and not deactivating M1's POAHC. The facility did not develop a care plan to address M1's difficulty accepting and/or feelings of anger regarding diagnosis of dementia and needing POAHC activated to involve POAHC agent in making health care decisions.

A physician's note dated 8/9/16, documented M1 has an activated POAHC which M1 did not appreciate. M1 is being re-evaluated for a possible reversal (deactivation) of the POAHC.

A Care Conference Note dated 8/9/16, documented M1 talking about reversing incompetence evaluation again (deactivating POAHC document).

A social services note dated 9/6/16, documented SW C, NHA (Nursing Home Administrator) A met with M1 and explained M1 must have a decision

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maker for healthcare. Staff discussed the results of the third evaluation to deactivate the POAHC. The note documented M1 became tearful and indicated M1 understood why member still needed a decision maker. The note did not document if staff explained M1 could name brother as agent or void the document if desired. The note did not document if staff explained if M1 voided the POAHC the facility may have to petition for guardianship.

A physician's note dated 9/8/16, documented M1 was moved to the second floor. The note documented M1's POAHC document which M1 would like changed, and to do what M1 needs; a different POAHC. M1 expressed daughter (POAHC agent) is not managing member well.

On 10/18/16, MDS (Minimum Data Set) Coordinator N documented a Late Entry regarding a meeting with M1 for M1's Annual MDS interview. MDSC N documented R1's diagnoses of vascular dementia, and explained to M1 what dementia was, but M1 was adamant that M1 doesn't have "any of it." M1 expressed how much member disliked member's physician and member told physician he was wrong. M1 also stated not liking and not speaking with the psychologist any longer because psychologist will not reverse M1's competency (incapacity).

On 12/8/16 at 10:43 a.m., S(Surveyor)14108 interviewed MDSC N regarding her interview with M1 documented on 10/18/16. MDSC N verified M1 was upset regarding POAHC not being deactivated and M1's difficulty accepting diagnosis of dementia. When asked who would be responsible for developing a care plan to address these issues, MDSC N indicated the

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social worker would be responsible to develop the care plan. MDSC N could not recall speaking with the social worker regarding M1's issues.

M1's medical record did not contain any documentation by SW C regarding M1's continued complaints or feelings of anger related to the activated POAHC or M1's diagnosis of dementia to staff and M1's physician.

A physician's note dated 11/1/16, documents M1 being upset about the POAHC being enacted (activated), but has not been able to fulfill objective criteria to allow that to be done (deactivated) and/or difficulties getting it reversed. Plan: Discuss care plan with nursing staff and social work and patient.

On 12/7/16 at 12:50 p.m., S14108 interviewed SW C regarding M1 and M1's medical record. SW C indicated she did ask M1's brother if he would consider being M1's POAHC agent, but he declined because he did not want any family arguments. SW C when asked, did indicate she explained to M1 that M1 could fire her POAHC agent, but then the facility would have to petition for guardianship which would have to be paid for. SW C indicated M1 told staff M1 would keep POAHC as it was. SW C verified she had not documented these discussions with M1 in M1's medical record.

On 12/8/16 at 11:00 a.m., SW C again verified to S14108 that she did document all the work she had done with M1 regarding dealing with M1's activated POAHC, even though M1 had been assessed three times regarding deactivating M1's POAHC.

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F 514	Continued From page 31 On 12/8/16 at 11:30 a.m., S14108 met with ADON (Assistant Director of Nursing) E, DON (Director of Nursing) O and NHA A regarding M1. NHA A indicated he recalled SW C explaining to M1 that member could fire the POAHC agent and what would happen if member did. Staff agreed they should have documented the discussions with M1 and M1's family regarding the POAHC and M1's feelings of anger regarding the activated POAHC and diagnosis of dementia.	F 514		