

DHHS, Division of Public Health  
Licensure Unit  
301 Centennial Mall South  
P.O. Box 94986  
Lincoln, NE 68509-4986

### INSPECTION REPORT

Facility: Life Quest at the Coolidge Center  
201 Commercial Street, Palmer, NE 68864  
Licensed Beds: 55  
License Number: MHC043  
Completed: July 21, 2017

***19-006.01 Licensee: The licensee must determine, implement and monitor policies to assure that the facility is administered and managed appropriately. The licensee's responsibilities include:***

- 1. Monitoring policies to assure appropriate administration and management of the facility;***
- 2. Ensuring the facility's compliance with all applicable state statutes and relevant rules and regulations;***
- 3. Ensuring the quality of all services, care and treatment provided to clients whether those services, care or treatment are furnished by facility staff or through contract with the facility;***
- 4. Designating an administrator who is responsible for the day to day management of the facility;***
- 5. Defining the duties and responsibilities of the administrator in writing;***
- 6. Notifying the Department in writing within five working days when a vacancy in the administrator position occurs, including who will be responsible for the position until another administrator is appointed;***
- 7. Notifying the Department in writing within five working days when the administrator vacancy is filled indicating effective date and name of person appointed administrator;***
- 8. Ensuring clients are provided with a stable and supportive environment, through respect for the rights of clients and responsiveness to client needs;***
- 9. Receiving periodic reports and recommendations regarding the quality assurance/performance improvement (QA/PI) program;***
- 10. Implementing programs and policies to maintain and improve the quality of client care and treatment based on QA/PI reports; and***
- 11. Ensuring that staff levels are sufficient to meet the clients' needs.***

This standard is not met as evidenced by:

Based on record review, interviews, and observations, the licensee who was also the Administrator, failed to establish and monitor the facility's policies and procedures to assure appropriate administration and management of the facility and compliance with the applicable regulations.

Findings:

The Licensee failed to:

A. Ensure the facility established necessary policies and procedures to provide guidance to staff and to ensure implementation of existing policies. See examples under the regulations cited in this inspection report.

B. Ensure the facility was in compliance with 175 NAC 19, Regulations Governing Licensure of Mental Health Centers. See examples under the regulations cited in this inspection report.

C. Ensure the Administrator performed the essential administrative and management duties for the mental health center as evidenced at 175 NAC 19-006.02 and throughout this inspection report.

D. Ensure quality of all services met the needs for all 52 clients served, provided by the facility or through contracted services as evidenced at 175 NAC 19-006.10 Care and Treatment Activities Provided, 175 NAC 19-006.13 Client Assessment Requirements, 175 NAC 19-006.14A Individual Service Plan, 175 NAC 19-006.15 Supportive Services, 175 NAC 19-006.16E Administration of Medication, 175 NAC 19-006.19B Discharge Plan and other examples under the remaining regulations cited in this inspection report.

E. Ensure the clients were provided a safe, supportive and stable environment. See examples under the regulations cited in this inspection report.

F. Ensure staff levels were sufficient and staff were trained to meet the clients' needs at all times, as evidenced at 175 NAC 19-006.03 Staffing Requirements and 175 NAC 19-006.03A Facility Staffing and other examples under the remaining regulations cited in this inspection report.

***19-006.02 Administration: The Administrator is responsible for planning, organizing, and directing the day to day operation of the mental health center. The Administrator must report and be directly responsible to the licensee in all matters related to the maintenance, operation, and management of the facility. The Administrator's responsibilities include:***

- 1. Being on the premises a sufficient number of hours to permit adequate attention to the management of the mental health center;***
- 2. Ensuring that the mental health center protects and promotes the client's health, safety, and well-being;***
- 3. Maintaining staff appropriate to meet clients' needs;***
- 4. Designating a substitute, who is responsible and accountable for management of the facility, to act in the absence of the administrator.***
- 5. Developing procedures which require the reporting of any evidence of abuse, neglect or exploitation of any client served by the facility in accordance with Neb. Rev. Stat. Section 28-732 of the Adult Protective Services Act or in the case of a child, in accordance with Neb. Rev. Stat. Section 28-711; and***
- 6. Ensuring an investigation is completed on suspected abuse, neglect or exploitation and that steps are taken to prevent further abuse and protect clients.***

This standard is not met as evidenced by:

Based on record reviews and interviews the Administrator failed to provide the necessary oversight and direction of the facility. These violations were evidenced by the facility administrator's failure to:

- A. Protect clients' health, safety and well-being as evidenced at 175 NAC 19-006.10 Care and Treatment Activities Provided, 175 NAC 19-006.13 Client Assessment Requirements, 175 NAC 19-006.14A Individual Service Plan, 175 NAC 19-006.16E Administration of Medication and 175 NAC 19-006.16E1c Provision of Medication by a Person other than a Licensed Health Care Professional and throughout this Inspection Report.
- B. Ensure sufficient numbers of staff were on duty at all times to meet client needs as evidenced at 175 NAC 19-006.03 Staff Requirements and 175 NAC 19-006.03A Facility Staffing and throughout this Inspection Report.
- C. Ensure staff were properly trained as evidenced at 19-006.03D Staff Training and 19-006.03D2 Ongoing Training in this Inspection Report.
- D. Ensure care and treatment was provided to all clients to meet their needs as evidenced at 19-006.08 Care and Treatment Requirements; 19-006 and throughout this Inspection Report.
- E. Ensure investigations were completed by the facility of suspected abuse, neglect or exploitation and that steps were taken to prevent further abuse to protect clients.

Review of facility policy "Internal Investigation Policy" (undated) found the Administrator shall perform an internal investigation anytime there is an allegation or complaint or suspicion against a staff member or another Resident which could cause potential harm or any safety issue for any Resident, or suspected misappropriation of property or money. The Internal Investigation Report shall contain all investigative procedures performed, all witness statements, any pertinent information obtained from other records, findings of Law Enforcement if applicable, notifications made, any interventions resultant from alleged complaint or accusation, and preventative measures taken to ensure that proper policies and procedures are followed. All Internal Investigations will be completed by the Administrator no later than 5 working days of the notification of the allegation/grievance. A copy of the Internal Investigation will be sent to the Adult Protective Services, local office. The report will be filled out completely with no exceptions. All suspected abuse/neglect/exploitation must be reported on.

A request of facility investigations was requested from the Administrator on 7/11/17. There was no documentation that an investigation had been conducted on the following incidents found in client records or reported by clients and of steps taken to prevent further abuse and to protect clients:

1. Altercation between client 10 and 18 on 6/18/17. Law Enforcement called 2 times by client 18. Client 10 was ticketed by law Enforcement.
2. Client 10 hit 31 on 1/19/17. Client 31 received injuries to upper lip, requiring stitches.
3. Client 10 pushed Client 11 who was in hallway with walker to the ground and kicked Client 11 in the stomach on 3/1/16.

4. Client 10 had a pocket knife and showed it to Staff on 1/15/16. Client 10 threatened to cut themselves, stab other clients and leave the property. Staff locked themselves in the medication room and notified the Administrator who instructed staff to call 911.
  5. Client 27 slapped Client 47 on 7/11/17 on the back of the head at least two times. Client 47 then slapped client 27 on the forehead leaving a dime sized red mark.
  6. Client 18 reported on 7/10/17 to survey team that client 24 used a knife on Client 11 at lunch. Client 18 stated the LPN had taken the knife away and did not do anything else. There was no documentation in client records regarding this incident.
  7. Client 18 was verbally aggressive to staff and clients on 7/13/17. Client 18 reported to staff that multiple clients were threatening client 18.
  8. Survey team reported on 6/9/17 to facility staff that Client 13 was walking west approximately 3 blocks from the facility. Staff reported not being aware client 13 was not in the facility. Client 13 was found and returned to the facility approximately 40 minutes from time of reporting the incident to the facility approximately 2.2 miles from the facility.
  9. Client 61 arrived by a cab to the facility on 7/20/17 at 5:00pm as a new admission from a hospital. Client 61 had left the facility and was reported to the facility by community individual that a client was on someone's grass under a sprinkler by the railroad tracks. Before staff arrived and ambulance had been called and Client 61 was taken to the hospital.
- Note: Additional details on these incidents can be found under Rights at 175 NAC 19.006.04B.

- F. Ensure the facility reported any evidence of abuse, neglect or exploitation in accordance with Neb. Rev. Stat 28-732 of the Adult Protective Services Act.

Review of facility policy "Policy for Reporting Abuse" (undated) found Life Quest policy is to take any allegation of abuse and neglect or misappropriation of funds, seriously and without hesitation, follow the state regulations for reporting abuse and neglect. If there are any reports of abuse it must immediately be reported to the administrator who then will report to Adult Protective Service. If the abuse is resident to resident the physical harm will also be reported to Adult Protective Service.

There was no evidence provided that the incidents stated above were reported to Adult Protective Services. There was evidence that Law Enforcement was notified, but this was to obtain the services of Law Enforcement to intervene.

**19-006.04 Client Rights**

**19-006.04A The facility must:**

- 1. Ensure that the client is aware of the rights listed in 175 NAC 19-006.04B upon admission and for the duration of the stay;**
- 2. Operate so as to afford the client the opportunity to exercise these rights; and**
- 3. Protect and promote these rights.**

**19-006.04B The client must have the right:**

- 1. To be informed in advance about care and treatment and of any changes in care and treatment that may affect the client's well-being;**
- 2. To self-direct activities and participate in decisions regarding care and treatment;**
- 3. To confidentiality of all records, communications, and personal information;**
- 4. To voice complaints and file grievances without discrimination or reprisal and to have those complaints and those grievances addressed;**
- 5. To examine the results of the most recent survey of the facility conducted by representatives of the Department;**
- 6. To privacy in written communication including sending and receiving mail consistent with individualized service plans;**
- 7. To receive visitors as long as this does not infringe on the rights and safety of other clients and is consistent with individualized service plans;**
- 8. To have access to a telephone where calls can be made without being overheard when consistent with individualized service plans;**
- 9. To retain and use personal possessions, including furnishings and clothing as space permits, unless to do so would infringe upon the rights and safety of other clients;**
- 10. To be free of restraints except when provided as in 175 NAC 19-006.12;**
- 11. To be free of seclusion in a locked room, except as provided in 175 NAC 19-006.12;**
- 12. To be free of physical punishment;**
- 13. To exercise his or her rights as client of the facility and as a citizen of the United States;**
- 14. To be free from arbitrary transfer or discharge;**
- 15. To be free from involuntary treatment, unless the client has been involuntarily committed by appropriate court order;**
- 16. To be free from abuse and neglect and misappropriation of their money and personal property; and**
- 17. To be informed prior to or at the time of admission and during stay at the facility of charges for care, treatment, or related charges.**

This standard is not met as evidenced by:

Based on observation, record review and interview the facility failed to promote and protect client rights. This had the potential to affect all 52 clients who resided at the facility at the time of the survey

Findings:

- A. Failed to ensure clients had the right to self-direct activities and participate in decisions regarding care and treatment.

Client 9 Observation on 7/10/2017 at 2:00pm, in the charting room found Client 9 wanted to speak with Staff A about their guardian, son, spouse and Client 9's lawyer. Staff A asked Client 9 if Client 9 was feeling anxious, and if Client 9 would like an Ativan (as needed medication-PRN) for their anxiety. Client 9 responded no. Client 9 continued speaking with Staff A and Staff A asked again if Client 9 would like an Ativan for their anxiety. Client 9 responded no and left the charting room. At 2:36pm, Client 9 returned and spoke to the LPN about an upcoming appointment. LPN asked Client 9 if Client 9 would like an Ativan for anxiety, Client 9 responded no, but maybe two Tylenol. The LPN stated the Tylenol would not

help the anxiety but an Ativan would. Client 9 responded the Ativan would make Client 9 sleepy and Client 9 would miss their appointment. The LPN asked Client 9 if they would like water or applesauce with their medication. Client 9 responded applesauce. The LPN provided an Ativan, not the two Tylenol as Client 9 had requested. Client 9 stated, "this is not Tylenol" and the LPN responded the medication was for Client 9's nerves and prompted Client 9 to take the medication. Client 9 took the medication. Review of Client 9's MAR (Medication Administration Record) found Client 9 was prescribed Tylenol for pain and Lorazepam (generic for Ativan) for anxiety as PRN medications.

Client 44 Observation on 7/10/2017 at 2:14pm found Client 44 requested their debit card from the facility, as Client 44 wanted to take the bus to Fremont. Client 44 stated as of June 3, 2016, Client 44 was their own payee and their own guardian and free to move out. Staff A told Client 44 they would need to give 30 day notice and if Client 44 left today they would leave without Client 44's money as the staff responsible for client finances was not on campus. Client 44 stated they had already told the Administrator/RN that if something opened up Client 44 was leaving the facility. Client 44 reported something had opened up and Client 44 was ready to leave. Client 44 stated Client 44's sibling was helping with the move. Staff A reminded Client 44 they would need their medications and Client 44 stated the facility would need to release their medications to Client 44. During the observation Staff A had been taking and making phone calls and filling out paper work. Staff A did not assist Client 44 further or finish the conversation with Client 44.

Interview with the LPN on 7/10/17 at 2:30pm found the Administrator/RN had spoken to Client 44's sibling. The Administrator/RN had cautioned the sibling about helping Client 44 leave the facility and stated that if the sibling were to assist Client 44 the Administrator would identify Client 44's leaving as AMA (against medical advice).

Interview with Client 44 on 7/11/17 at 8:52am reported as of June (2017), Client 44 had the right to live where they chose. Client 44 reported the facility did not provide useful teachings to clients to live in the community such as getting a checking account. Client 44 reported they had done everything they needed to do to move out and the facility was not helping in any way.

- B. Failed to ensure clients had the right to voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed.

Review of the facility policy "Grievance Procedure", (undated), found the facility recognized the need for clients, their guests, staff and others to have questions answered and problems solved. The Grievance Procedure was put into place to provide "prompt and fair" handling of issues. The procedure included the following steps:

1. Facility would keep a copy of the Grievance Procedure document, Grievance procedure forms, and the APS hotline number posted in a place accessible to clients, employees and guests.
2. A complaint may be presented orally or in writing on the grievance form. The form is turned into the Administrator/RN.
3. The complainant will explain the nature of the issue. The Administrator will investigate and upon completion will provide a proposed solution to the issue to the complainant within 1 week or less.

4. The Administrator/RN will work with the complainant until a reasonable solution satisfying all parties is reached.

Review of the facility policy "Internal Investigation Policy" (undated) identified the Administrator would perform an internal investigation any time there was an allegation, complaint or suspicion against a staff member or another client which could cause potential harm or any safety issue for any client. In addition, when a client submits a grievance or complaint, voiced or written, the findings of an investigation will be given to the client. Finally, the policy identified all internal investigations would be completed no later than 5 working days of the notification of the "allegation/grievance."

Interview with the Administrator/RN on 7/12/2017 at 2:50pm reported there had been no grievances filed in the last 12 months. The Administrator/RN stated any issues that arise are taken care by the staff or the Administrator/RN immediately so there is no need to fill out a grievance form.

Client 23 Interview with Client 23 on 7/14/2017 at 12:32pm, Client 23 reported they had shared concerns about Client 23's general health, lack of medications, lack of privacy with cares, and frequent falls with Client 23's walker, with staff all the way up to the Administrator/RN with no results. Client 23 stated the Administrator/RN does not stand up for Client 23 and that Client 23 feels "really scared" at the facility much of the time. Client 23 stated they did not want to talk too long because Client 23 did not want the Administrator/RN to get mad. Client 23 was unaware of a "grievance form" or the process, and did not know how to access. In addition, Client 23 added they were hesitant to ask because it would also cause problems with the Administrator/RN and other staff.

At the end of the interview the LPN was asked for a grievance form. The LPN stated they thought there should be one in the policy and procedure manual. The LPN found the form and made a copy. The grievance procedure was posted however accessibility to the form or to the APS hotline as identified in the procedure was not found. Additionally there was no evidence found that Client 23's concerns had been investigated by the facility.

C. Failed to ensure clients have the right to access a telephone where calls could be made without being overheard when consistent with clients' Individual Service Plans.

Review of Individual Support Plans (ISP) for the ten sampled clients found no stipulations regarding restriction of phone use by the clients.

Observation on 7/10/2017 at 1:15 found the public pay phone near the entrance of the facility was ringing. Incoming and outgoing phone calls made from this phone could not be kept private from anyone walking through the area. Interview with Staff A on duty at the time of the observation stated the telephone near the entrance was a pay phone and the facility's only public access phone used by the clients. Staff A reported once in a while clients were allowed to use the phone in the staff office/charting room however since that phone was the business line for the facility it needed to be kept open for business calls. Staff A stated clients would never be left alone in the office to make or take calls as the office held confidential information. Staff A acknowledged calls being made at the pay phone

E. Failed to ensure clients had the right to be free from abuse, neglect, and misappropriation of their money and personal property.

Client 10 and Client 18 Review of 6/8/17 Nurses Note for Client 10 found Staff A documented an incident at 7:05pm between Client 10 and Client 18. Client 10 responded to a request made by Client 18 with racially explicit language and threatened physical aggression by raising Client 10's fists to Client 18. Staff A stepped between the two clients and attempted to de-escalate the situation. Client 10 returned to their room and Client 18 continued to be verbally aggressive. The Administrator/Registered Nurse (RN) was notified.

Review of 6/8/2017 Nurses Note entry for Client 18, documented Law Enforcement was on campus at 7:40pm and returned at 8:30pm, called both times by Client 18.

Interview with Staff A at 10:10am on 6/9/2017 reported, Client 18 asked Client 10 to get another client for the phone. Client 10 refused and used racially explicit language and then attacked Client 18. Staff A reported before any contact was made Staff A stepped between and de-escalated Client 10 who returned to their room. Client 18 remained escalated and called Law Enforcement. When Law Enforcement arrived they spoke to Client 10 and Client 18 and ticketed Client 10. Client 10 was upset but returned to their room in the Annex residential building. Client 18 continued to escalate and continued to harass Client 10. Client 18 then called Law Enforcement a second time. Law Enforcement returned and told Client 18 to remove themselves from the area and to stop harassing Client 10. Staff A stated they intervened only at the threat of physical harm by Client 10. Staff A stated they were to have been off duty at 7:00pm. However Staff A stayed to deal with the incident because the staff on duty, Staff I was unable to handle the situation.

Interview with Client 18 on 6/9/2017 at 8:39am reported they had been at the facility since July 2016. Client 18 reported Client 10 had attacked Client 18 the night before. Staff A was on duty intervened with Client 10 and Client 10 returned to their room. However Client 18 stated Client 10 had still tried to hit Client 18 and staff had not done anything so Client 18 called Law Enforcement. Client 18 stated this was Client 10's 3<sup>rd</sup> assault charge. Client 18 stated Client 10 had assaulted Client 31 a month ago and got a ticket. Client 18 stated they could not use the facility "client" phone because it does not call out without money; however Client 18 stated they used their own cell phone and called Law Enforcement.

Client 10 and 31 Review of the 1/19/2017 Behavioral Incident report found Client 10 threatened and hit Client 31 in the head and face. Client 31 received injuries to their upper lip. Client 10 returned to their room. Staff assessed Client 31's injuries and took Client 31 to the Emergency room for stitches.

Review of Law Enforcement report dated 1/19/17 found Client 10 received a citation for criminal mischief and third degree assault.

Client 10 and Client 11 Review of Behavioral Incident report and Incident/Accident report dated 3/1/2016 found Client 10 was trying to pick a fight with clients and staff and yelling in the dining room. Client 11 was eating breakfast when Client 10 hit Client 11 in the head. Client 11 left the dining room and walked down the hallway with Client 11's walker when Client 10 pushed Client 11 to the ground and kicked Client 11 in the stomach.

Client 10 Review of Behavioral Incident report dated 1/15/2016 found Client 10 went to the medication room and showed a pocket knife to Staff A. Client 10 threatened to cut themselves, stab other clients, and to leave the property. Staff I locked themselves in the medication room and notified the Administrator/RN who instructed Staff I to call 911.



Client 27 and client 47 Review of 7/11/17 incident report found Client 27 slapped Client 47 on the back of the head. Client 27 asked Client 27 to stop; however Client 27 did it again. Client 47 then slapped Client 27 on the forehead which left a dime sized red mark on Client 27's forehead.

Client 18, Client 24, Client 11 Client 18 reported to the survey team on 7/10/2017 at 3:45pm that Client 24 had used a knife on Client 11 during lunch. Client 18 reported the LPN had taken the knife away however Client 18 reported staff didn't do anything else about the knife.

There was no further documentation found in an incident report or Nurses Notes of this incident between Client 24 and Client 11.

Client 18 Review of Nurses Note for Client 18 dated 7/12/2017 found Client 18 was asked to clear belongings from the hallway. Client 18 began yelling and being verbally aggressive to staff and clients.

Review of Nurses Note for Client 18 dated 7/13/2017 found Client 18 reported to staff that multiple clients were threatening Client 18. There was no evidence of follow-up by staff.

Client 15 Observation on 6/6/2017 at 8:02am as the survey team was walking to the front door of the facility, the team observed Client 15 asking other clients for a cigarette. Client 15 was observed to have an oxygen cannula with tubing around Client 15's neck. Upon entering the facility a large green oxygen tank on wheels was by the front door. Staff A, the only staff on duty at the time, was in the charting/staff room. Staff A was asked if this was usual procedure for Client 15 who uses oxygen to be smoking. Staff A looked out the front door saw Client 15 smoking and went outside to retrieve Client 15. Staff A brought Client 15 into the building and assisted Client 15 with hooking up Client 15's oxygen. When Staff A returned to the survey team Staff A stated Client 15 knows better than to smoke. There was no further follow-up provided as a result of finding Client 15 outside smoking and not using their oxygen.

Client 13 Observation on 6/9/2017 at 9:35am found Client 13 was walking west on Commercial St, the street that runs in front of the facility. Client 13 was about 3 blocks from the facility. Upon entering the facility, the survey team asked the staff on duty Staff A if Client 13 was to be walking alone away from the building towards the edge of town. Staff A stated they had no idea that Client 13 had left the facility. Staff A went out the front door, observed that Client 13 had left the facility and called Staff B. Staff A was the only staff on duty at the time and was unable to leave the facility. Staff B was doing transport and was available to go find Client 13 who was now out of visual range of the facility. Client 13 was returned back to the facility at approximately 10:15am by Staff B.

Review of Nursing Note entry 6/9/2017 for Client 13 found Staff B had arrived for work at 8:45am and was told that Client 13 had been seen walking towards Worms Road west of the facility. Staff B took the facility van and found Client 13 walking on the south side of the road traveling west. Staff B got Client 13 into the van and returned to the facility. Google calculated Client 13 was found approximately 2.2 miles from the facility.

Client 12 On 3/20/16, staff could not locate Client 12 for 8:00pm medication pass. Law Enforcement was notified. Client 12 returned to the facility at 10:30am on 3/21/16. The Law Enforcement document identified Client 12 returned on 3/21/16 at 2:14pm.

Client 23 Interview with Client 23 on 7/14/2017 at 12:32pm reported Staff A and Staff M make fun of clients while they handed out medications. Client 23 reported some of Client 23's cares were done in the hallway in front of other clients, such as caring for the sores on the back of Client 23's legs. Client 23 reported they would have to drop their pants so staff could apply the necessary cream.

Client 19 and Client 47 Review of facility investigation dated 7/17/17 found the following: Client 17 reported having sex with Client 47 in client 19's bedroom on two different occasions which was Skyped for others to see. Client 19 confirmed having sex with client 19 which was Skyped.

Client 2 and Client 33 In an interview on 7/10/17 at 4:20pm with Client 2, found Client 2(female) showed their breasts to Client 33 (a male client) to earn a pop. Client 2 stated Client 33 asked most of the females residing at the facility to come to Client 33's bedroom and show Client 33 their breasts in exchange for pop or \$1.00. In an interview on 7/11/17 at 10:45am, Client 33 reported they had given pop and money to female clients residing at the facility for showing their breasts and to "give me blowjobs." Client 33 stated these acts took place in Client 33's bedroom. Client 33 reported they had a criminal history of sexual abuse and spent time in jail. Client 33 stated Client 33 had been diagnosed with impulse control issues and was not currently receiving routine counseling as Client 33 had in the past.

Review of the Nebraska Sex Offender Registry found Client 33 was registered as a Lifetime Offender.

Clients perform work for facility. Interview with Staff B on 6/8/2017 at 10:47am stated there was no housekeeper at this time so cleaning was the staff's responsibility.

Interview with Staff G the facility cook on 6/8/2017 at 10:10am reported they did most of the cooking, except breakfast and on the weekends.

Interview with Staff A on 7/12/2017 at 3:35pm stated usually the clients cleaned the facility and cooked breakfast on the weekends.

Interview with the Administrator/RN on 7/12/2017 at 5:31pm reported there are no "for pay" jobs at the facility. Clients will volunteer when they see things that need to get done. The Administrator/RN stated they reward clients when they volunteer with things like steaks and fireworks on the 4<sup>th</sup> of July; and concert tickets.

Client 24 Observation on 6/6/2017 at 8:14am found Client 24 (identified by Staff C) with a mop and bucket mopping the hallways.

Observation on 7/13/2017 at 10:15am found Client 24 cleaning the hallways and public bathrooms.

Interview with Client 24 on 6/8/2017 at 9:04am found they were in charge of cleaning the public bathrooms and the two hallways. Client 24 reported they also clean the kitchen, the counter tops, corners, crevices, and the toaster. In addition, Client 24 reported they regularly cook breakfast and Client 16 cooks as well.

Interview with Client 24 on 7/11/2017 at 8:15am Client 24 reported they had been doing the dishes in the morning and in the evening until the previous week. Client 24 stated Client 10, Client 4 and Client 12 did dishes or worked in the kitchen and Client 45 served the food.

Client 24 stated the Administrator/RN considered the jobs and janitorial work as “volunteer work” and that the Administrator did not pay Client 24 in cash but in candy bars, bags of candy and stuff from the Dollar General Store.

Client 16 Observation on 6/9/2017 at 8:20am found Client 16 coming out of the kitchen. Client 16 reported they cooked breakfast “mostly every day”.

Observations on 7/10/17 at 2:25pm and 2:58pm found Client 16 helped to clean the sink and mopped the floors of the staff bathroom and communal use bathrooms.

Interview with Client 16 during the 7/10/17 observation found Client 16 cleaned the toilets, sinks, and showers once a day. Client 16 reported both Client 16 and Client 24 clean the restrooms. Client 16 stated they volunteered to clean and did not get paid for the cleaning.

Client 18 Interview with Client 18 on 6/9/2017 at 8:39am found Client 18 wanted to know why they were not allowed to do their jobs if the survey team was on campus. Client 18 stated they were told by staff that nobody would be doing their jobs while the survey team was at the facility.

Client 10 Observation on 7/10/2017 at 1:15pm found Client 10 in the dish room spraying off dishes and Staff A the only staff on duty was in the kitchen. Interview of Staff A found Client 10 was doing dishes for community service for no pay.

In an interview on 7/10/17 at 1:26am, Client 10 reported they did not get paid for doing dishes and cleaning around the facility. Client 10 stated the Administrator/RN allowed Client 10 to do these jobs in order to work off community service hours Client 10 had acquired due to legal problems.

Client 4 Observation on 7/10/2017 at 5:20pm found Client 4 standing by the dishwasher, rinsing dishes at the sink. When Client 4 saw the survey team Client 4 stopped spraying dishes took off Client 4’s apron and left the dishwashing area.

Interview with Client 4 on 7/14/17 at 11:50am found Client 4 works up to twenty hours a week in the kitchen with Client 16.

Client 45 Interview on 7/13/17 at 2:20pm with Client 45 reported they “volunteered” to do laundry for the facility and Client 9, Client 23, Client 35, and Client 52’s personal laundry because these clients were “crippled up and not in good shape.”

Administration Threats to clients. Administration threaten clients to withhold their personal monies and properties.

1. Observation on 7/12/2017 at 5:30pm found Staff B stated to the clients prior to dinner being served that all rooms were going to be cleaned and checked by staff prior to personal monies being handed out the following morning, 7/13/2017.

Interview with Administrator/RN on 7/12/2017 at 5:45pm stated they had directed Staff B to explain to clients that rooms had to be cleaned and inspected prior to receiving their personal funds on Thursday, July 13, 2017, because the Administrator/RN was not going to tolerate how dirty the facility had

become. The Administrator stated clients would be given their personal funds, this was really just a threat. The Administrator/RN stated they had to do something so clients would clean their rooms.

Observation on 7/13/2017 at 8:00am found clients cleaning rooms with staff assistance or independently. Staff inspected client's rooms and afterwards directed clients to get their personal funds.

Interview with Staff B on 7/14/2017 at 3:30pm stated they had been directed by the Administrator/RN to tell clients they would not be receiving their personal funds until rooms were cleaned and inspected by staff on 7/13/2017.

2. On 7/12/2017 at 10:00am Client 48 reported to the survey team the clients had been told by staff that because they were using their own phones to call Law Enforcement, when it was not necessary (as determined by the staff), phones would be confiscated. Client 48 was upset and concerned on the possibility that the facility could confiscate client personal cell phones.

Interview with the Administrator/RN on 7/12/2017 at 2:50pm stated, yes the clients had been told misuse of their personal cell phones would be cause for their phones to be confiscated, however at this time no phones had been taken. The Administrator stated, "What else can I do?"

***19-006.10 Care and Treatment Activities Provided The facility must provide for the following care and treatment activities to meet client needs on an ongoing basis in a manner that respects clients' rights, promotes recovery and affords personal dignity:***

- 1. Provision of adequate shelter and arrangements for food and meals;***
- 2. Provision of care and treatment to meet client identified needs;***
- 3. Medical and clinical oversight of client needs as identified in the client assessment;***
- 4. Assistance with acquiring skills to live as independently as possible;***
- 5. Assistance and support, as necessary, to enable clients to meet personal hygiene and clothing needs;***
- 6. Assistance and support, as necessary, to enable clients to meet their laundry needs, which includes access to washers and dryers so that clients can do their own personal laundry;***
- 7. Assistance and support, as necessary, to enable clients to meet housekeeping needs essential to their health and comfort, including access to materials needed to perform their own housekeeping duties;***
- 8. Activities and opportunities for socialization and recreation both within the facility and in the community;***
- 9. Health-related care and treatment; and***
- 10. Assistance with transportation arrangements.***

This standard is not met as evidenced by:

Based on record review, interview, and observations the facility failed to provide care and treatment to meet individuals' needs and promote recovery for 10 of 10 sampled clients and 10 clients added for review. (sampled clients: Client 1, Client 2, Client 3, Client 4, Client 5, Client 6, Client 7, Client 8, Client 9, Client 10), (added for review: Client 15, Client 16, Client 21, Client 24, Client 30, Client 32, Client 34, Client 39, Client 48, and Client 50). This potentially effected the other 32 clients at the facility.

## Findings:

Review of the facility policy titled “Life Quest Mental Health Center Program Description” (dated 4/1/13) identified the facility offered and provided services to enhance and promote quality of life and well-being to individuals served. The program description identified the facility would provide care and treatment activities which included: weekly psychiatric services by an Advanced Practical Registered Nurse (APRN), therapy/counseling services by a Licensed Mental Health Practitioner two times per week, assessment and monitoring of client’s needs at admission and ongoing to ensure appropriateness of placement, development of Individual Service Plans (ISP) to address mental health, medical, and behavioral needs and emergencies. The facility would provide daily nutritious meals and snacks, laundry services, Adult Day Program, and a safe, clean, and maintained environment.

- A.** Failed to provide access to routine and ongoing therapeutic care and treatment activities to meet client’s mental health, social/recreation, and behavioral needs and promoted recovery and independence.

Interviews on 7/12/17 at 3:00pm and 7/13/17 at 2:40pm the Administrator/Registered Nurse (RN) reported the facility provided daily therapeutic activities (identified as “groups”), psychiatric and medication supports via tele-med treatment with a psychiatric Advanced Practice Registered Nurse (APRN), and counseling supports from a Licensed Independent Mental Health Practitioner (LIMHP). The Administrator/RN stated the facility used workbooks to facilitate the therapeutic group activities which focused on: psychiatric and mental illnesses, medication awareness, self-esteem, care plans, behavior/anger management, communication, coping skills, daily living skills, and social skills. The facility had a calendar identifying therapeutic activities, tracked client group attendance, and recorded client progress and participation. The Administrator/RN stated “I think we do a good job” with addressing client mental health needs.

Interviews on 7/10/17 at 5:27pm and 7/14/17 at 11:20am the Licensed Practical Nurse (LPN) stated the facility provided daily therapeutic groups which addressed client mental health care and treatment and social activities. The LPN reported the LPN occasionally conducted groups which addressed topics related to nursing supports, client medical and physical health, and safety in hot/cold weather.

Review of the facility’s Groups/Activity calendar and attendance documents for April, May, June and July 2017 found clients had the opportunity to participate in 288 therapeutic group and daily care activities (80 in April, 92 in May, 88 in June, and 28 from July 1-12, 2017). The group/activity calendar topics were the same for all 52 clients, as each session was to include all 52 clients at same time and location. Further review of these monthly calendars found:

- 1) Therapeutic mental health groups were scheduled to be conducted on Wednesday and Thursday at 9:30am and 10:30am (one hour sessions). Therapeutic mental health topics included coping skills, anger management, mental health awareness-depression, substance abuse, practical life skills, and resident rights and rules.
- 2) Client care and daily living groups were scheduled to be conducted on Monday, Tuesday, and Friday at 9:30am, 10:30am, and 1:00pm (one hour sessions) which included: cleaning and laundry skills,

movies, nursing health issues, resident meetings, bible study, music appreciation, board and card games, crafts and off-site trips to the recreation center, library, Humane Society, and personal shopping. In addition, at 9:00am Monday through Friday exercise activities were scheduled to occur in the dining room. Each Saturday was scheduled for leisure and social skills and Sunday was scheduled for church and movies.

Interview with the Administrator/RN and LPN on 7/12/17 at 3:00pm found participation in group sessions would be found in clients' activity progress notes and participation in therapy with licensed professional would be found in the client nursing notes.

Observations during the survey found the following:

1) On 7/10/17 from 1:15pm until 7:15pm no therapeutic group activities were conducted. During this time the lights were out in the dining room, not set up for activities, no staff or clients' present. Clients were observed to walk up and down the hallways, be outside sitting on benches and chairs smoking and conversing with one another, and/or in their bedrooms sleeping, watching television, or playing on electronic devices.

2) On 7/11/17:

9:00am exercise group was scheduled, however there was no participation by clients;  
10:00am until 11:30am a group session on addictions was scheduled for all clients. Observations at 10:00am found 25 of 52 clients did not attend the group session in the dining room, presented by the Administrator/RN. Observations of clients not participating were: one client slept, and other clients walked in and out of the dining room. Observations found clients residing in the annex building sat outside and smoked, up to six clients were observed to be smoking at the front entrance, and two other clients were seen smoking at the east doors.

3) On 7/12/17:

9:00am exercises to Richard Simmons exercise video was scheduled, however observation of the exercises found Client 48 started the video and left the dining room, Client 31 played a video game on their cell phone, and Client 34 and Client 41 sat at the dining tables then left.  
10:00am and 1:00pm movie was scheduled, however observations found during the movies clients would walk in and out of the dining room occasionally sitting and watching the movie, then walked the hallways, up to five clients were seen smoking at the front of the building.

4) On 7/13/17 movie playing after breakfast, at 9:00am exercise video, 9:30am coping skills group, and 1:00pm movie or attend recreation center outside of facility.

5) On 7/14/17 at 10:00am bible study and at 1:00pm clients went personal shopping and recreational activities outside of the facility. Observation of the bible study group found 16 clients attended and participated in discussions. Additional observations found 4 clients were smoking outside the front entrance, while other clients were in their bedrooms.

The following record review and interviews identified the facility failed to provide therapeutic care and treatment activities to meet Client 1, Client 2, Client 3, Client 4, Client 5, Client 6, Client 7, Client 8, Client 9, and Client 10 mental health needs.

#### Client 1

Review of Client 1's Face Sheet (undated) found Client 1 was admitted 7/10/12. Review of Client 1's record found the following documents identified Client 1's care and treatment needs:

1. Individual Service Plan (ISP) dated 1/18/17 (renewal) identified diagnosis of Paranoid Schizophrenia, Major Depression, Anxiety.
2. Life Quest Mental Health Assessment dated 7/10/12 identified inappropriate thoughts, thought disorder, and absent insight thoughts; impaired judgment, impulse control, memory, concentration, and attention; angry, anxious, agitated, stubborn, and hostile behavior; obsessive disorder (hoards items) and resistive to change.
3. Functional Assessment dated 7/18/16 identified: confusion, difficulty remembering details, forgetfulness, refuses to let others assist, does not socialize with peers, needs complete supervision and requires financial trustee/payee.

Observation of Client 1's bedroom found the door to be closed throughout the survey. Client 1 isolated their self in their bedroom, participated in no therapeutic groups or activities, and ate meals in their bedroom. Client 1 left their room briefly on 6/8/17 and 7/13/17 to receive their spending money. Client 1 refused an interview with the surveyor on 7/12/17 at 9:55am.

Interview with the Licensed Practical Nurse (LPN) on 7/12/17 at 11:00am found Client 1 isolated their self, refused to leave their bedroom to socialize with peers, and did not participate in therapeutic group or daily care activities.

Interview with Staff C on 6/7/17 at 9:00am and Staff A on 7/12/17 at 10:00am reported Client 1 stayed in their room all the time.

Review of Client 1's record found no evidence the facility had a care and treatment plan to address Client 1's mental health needs.

Review of Client 1's Discharge Plan (dated 1/24/17) identified Client 1 refused any and all psychiatric services, however, needed to see a psychiatrist due to paranoid schizophrenia, depression and isolative behavior.

Review of Client 1's record Nursing Note dated 11/26/15 through 7/7/16 found no evidence Client 1 received mental health treatment from a licensed professional who had within their scope of practice the ability to assess, diagnose, and provide mental health treatment.

Review of the therapeutic mental health groups the facility scheduled on the calendar and daily care activities for April, May, June and July 12, 2017 found Client 1 attended 0 of 288 group activities.

## Client 2

Review of Client 2's Client Face Sheet (undated) found Client 2 was admitted 9/14/15. Review of Client 2's record found the following documents identified Client 2's care and treatments needs:

1. Life Quest Mental Health Assessment dated 9/14/15: Schizoaffective disorder, general anxiety, PTSD, Dissociative disorder, Bi-polar disorder, delusions, sad and flat affect, illogical thought processes, very impulsive, and aggression. History of sexual, physical, and emotional abuse. History of self-harm and suicidal attempts (medication overdose).
2. Functional Assessment dated 3/28/16: Remains in room and doesn't socialize. And needs assistance with finances, use of kitchen equipment/food preparation, and administration of medication.
3. Nursing Assessment dated 9/14/15: Schizoaffective disorder-Bi-polar type, Borderline Personality disorder, Major Depression, PTSD, Protein deficiency, history of seizures, and scars on thighs from self-harm (cutting).
4. Suicide/Self-Harm and Elopement Risk Assessment dated 10/16/15, 10/21/15, and 10/30/15 identified Client 2 was an elopement risk and suffered from suicidal ideations.
5. ISP dated 3/21/17: Schizoaffective disorder, Bi-polar type, PTSD, Borderline Personality disorder, Major Depression, Protein deficiency, history of seizures. Client 2's ISP therapeutic mental health interventions included: (a) The LIMHP would provide individual therapy monthly and as needed; (b) The psychiatric APRN would monitor psychotropic medications for effectiveness and side effects every three months and as needed; and (c) Staff would encourage Client 2 to attend and participate in each of day program activities.

Review of Client 2's record found no evidence the facility had provided care and treatment or developed a treatment plan to teach Client 2 how to manage Client 2's mental health needs, suicidal ideations, elopement issues, and independent living skills identified in assessments.

Review of Nursing Note from 1/30/17 through 7/14/17 found no evidence Client 2 received monthly 1:1 counseling treatment with the LIMHP or another licensed mental health professional who had within their scope of practice the ability to assess, diagnose, and provide mental health treatment.

Review of the facility's therapeutic group/activity calendar and attendance documents for April, May, June 2017 and July 1 through July 12, 2017 found Client 2 attended 65 of 288 therapeutic mental health activity groups scheduled.

Interviews on 7/10/17 at 3:55pm and 7/11/17 at 8:25am, Client 2 reported the following: their mental health needs were not being met by the facility. Client 2 was suffering from anxiety issues, thoughts of self-harm (cutting), hearing voices, and history of suicidal attempts and thoughts. The facility provided no "meaningful" therapeutic activities that taught Client 2 to be more independent with budgeting, health issues, medication administration, and cooking skills. Client 2 reported the weekly group schedule was room cleaning on Monday, the middle of week a group for anger control or "secondary emotions," and personal shopping on Friday. Client 2 stated they refused to participate in groups as they were pointless and did not "do a whole lot" for Client 2's mental health treatment. Client 2 stated they didn't need to learn in group therapy how to make paper Mache, plant flowers outside, or watch movies. Client 2 stated they believed it would be beneficial to have more mental health therapy groups. Client 2 reported they stopped seeing the LIMHP because "I don't like her method." Client 2 was not currently



seeing another therapist for treatment to meet their mental health needs. Client 2 reported the Administrator/RN and the Licensed Practice Nurse (LPN) did not listen to Client 2's concerns regarding Client 2's mental health and Client 2's wanting to move out of the facility. Instead they offered Client 2 psychotropic PRN medications.

### Client 3

Review of Client 3's Client Face Sheet (undated) found Client 3 was admitted on 6/6/17. Review of Client 3's record found documents that identified Client 3's care and treatment needs included:

1. Review of hospital discharge records dated 5/17/17 through 6/6/17 found Client 3 had a psychiatric disorder secondary to Huntington's disease; eloped to Texas, homicidal ideations (attempted to stab guardian and family with a butter knife), suicidal ideations, physical violence/aggression; and needed reminders to complete personal hygiene.
2. Nursing Assessment dated 6/6/17 identified Huntington's disease, depression, mood disorder, and hypertension
3. Life Quest Mental Health Assessment dated 6/22/17 identified mood disorder, depression, Huntington's disease, feeling sad, no energy, not sleeping well, needs help with medications, and remaining safe.
4. Functional Assessment dated 6/21/17: mental status-mild impairment, some confusion and forgetfulness.

Review of Client 3's record found no evidence the facility developed an Individual Service Plan (ISP) or treatment plan identifying what services and supports the facility would provide Client 3 to address Client 3's mental health needs, suicidal and homicidal ideations, elopement, and independent living skills.

Review of the therapeutic mental health groups and daily care activities from June 6, 2017 through July 12, 2017 found Client 3 attended 30 out of 104 therapeutic groups/activities. However, there was no evidence or rationale how these groups that the person did participate addressed Client 3's mental health needs. Examples of groups attended were: Life management skills, bible study, board games, bingo, outdoor activities, substance abuse, library, recreation center.

### Client 4

Review of Client 4's Client Face Sheet (undated) found Client 4 was admitted on 11/12/03. Review of Client 4's record found documents which identified Client 4's care and treatment needs which included:

1. Life Quest Mental Health Assessment dated 11/30/03: Bi Polar, Schizoaffective, anxiety disorder, paranoid type personality, lying, phone calls to order things using false names, destruction of property, cruelty to animals, impaired judgment, insight and impulse control, impaired attention and affect, inappropriate, anxious, and agitated behaviors.
2. Functional Assessment dated 5/23/16 identified Client 4 needed complete supervision and administration of meds, forgetfulness, withdraw, and disruptive, and combative behaviors.
3. Mid Plains Center for Behavioral HealthCare Services, Inc. E/M Document dated 5/9/17 identified Client 4 required a structured day setting and be physically active.
4. ISP dated 5/23/17 identified Client 4's diagnosis was Schizoaffective disorder, Bipolar Type; Personality Disorder with Paranoid Traits. Client 4's ISP interventions identified the LIMHP

would work with Client 4 during monthly session or as needed and the psychiatric APRN would monitor psychotropic medications for effectiveness and side effects every month or as needed.

Review of Client 4's record found no evidence the facility had provided care and treatment or developed a treatment plan to address Client 4's mental health needs, medication administration, disruptive and combative behaviors, and independent living skills as identified above.

Review of Client 4's Nursing Notes from 5/9/16 until 4/28/17 found no evidence Client 4 received monthly 1:1 counseling treatment with the LIMHP or another licensed mental health professional who had within their scope of practice the ability to assess, diagnose, and provide mental health treatment. Client 4 met with the psychiatric APRN every two to three months (7/13/16, 10/11/16, 12/13/16, and 2/21/17) instead of monthly as identified in the ISP.

Review of the facility's therapeutic mental health groups/activities April, May, June 2017 and July 1 through July 12, 2017 found Client 4 attended 174 out of 288 groups/activities.

During interviews on 7/14/17 at 11:50am and 2:40pm, Client 4 reported they did not have a structured day that met their mental health needs. Client 4 reported having lived at the facility over 14 years and wanted to move out of the facility. Client 4 reported the Administrator/RN was their guardian and Client 4 is unable to make decisions about moving. Review of Client 4's "Face Sheet" and document "Letters of Guardianship for a Ward/Incapacitated Person" found the Administrator/RN was identified as Client 4's guardian.

#### Client 5

Review of Client 5's Client Face Sheet (undated) found Client 5 was admitted on 7/29/2016. Review of Client 5's record found documents which identified Client 5's care and treatment needs which included:

1. Resident Admission and Discharge Record dated 8/1/16: Developmental mental disorder, Psychosis unspecified
2. LIMHP assessment dated 8/17/16: below average intellect, impaired judgment, lack of control and attention.
3. Nursing Assessment dated 7/29/2016: Developmental mental disorder, Psychosis unspecified
4. ISP dated 2/21/2017 identified Client 5 was diagnosed with a Developmental Disorder and Psychosis (unspecified type). Further review identified Client 5's therapeutic interventions included staff would encourage attendance at therapeutic group activities and monitoring by the psychiatric APRN for psychiatric treatment and future psychiatric medication needs.

Review of Client 5's record found no evidence the facility provided care and treatment to address Client 5's mental health, impaired judgment, and issues with control and attention.

Review of Client 5's Nursing Note from 2/25/16 through 6/1/17 provided no evidence Client 5 received mental health treatment from a the LMHP, psychiatric APRN, or another professional who had within their scope of practice the ability to assess, diagnose, and provide mental health treatment.

Review of the therapeutic group/activity calendar and attendance sheets from April 2017 through July 12, 2017 found Client 5 attended 70 of 288 therapeutic mental health and activity group sessions.

Review of the Activity Progress Notes regarding therapeutic group participation from April 2017 through June 2017 identified Client 5 attended groups but faced their chair away and stared down the hallway, refused to participate, did not pay attention, and attended group sessions with little participation.

Observation of Client 5 during group time held on 7/11/2017 at 10:00am found Client 5 walked in and out of the group session multiple times and did not sit down to participate.

#### Client 6

Review of Client 6's Client Face Sheet (undated) found Client 6 was admitted on 4/14/2014.

Review of Client 6's ISP dated 5/23/17 identified Client 6's diagnosis and therapeutic mental health interventions included: Schizo-affective Disorder, history of Alcohol dependence and subsequent Dementia. Client 6 needed assistance with forgetfulness, anxiety, intrusiveness, anger, attention seeking, and alcohol use. The LIMHP would provide individual therapy to develop coping skills monthly and as needed. The psychiatric APRN would monitor psychotropic medications for effectiveness and side effects every two months and as needed. And staff were to remind Client 6 to attend and participate in group and self-help activities three times per week.

Review of Client 6's record found no evidence Client 6 received treatment specific to Client 6's anger control, anxiety, forgetfulness, and alcohol use.

Review of Client 6's Nursing Note from 10/12/16 until 7/14/17 found no evidence Client 6 received or attended monthly 1:1 counseling treatment with a licensed mental health professional.

Review of the facility's therapeutic group/activity calendar and attendance sheets from April 2017 through July 12, 2017 identified Client 6 attended 24 out of 288 therapeutic mental health groups scheduled. However, Client 6 did not attend any groups regarding anger control and alcohol use.

Observation of Client 6 during group on 7/11/2017 at 10:00am found Client 6 stood at the edge of the room during the therapeutic group presentation for two to three minutes but did not participate and then left.

Review of Client 6's Activity Progress Notes April 2017, May 2017 and June 2017 identified Client 6 attended groups with little participation or chose not to attend.

Interview with Client 6 on 7/14/2017 at 10:30am found Client 6 did not attend groups as provided by the facility as the groups did not apply to Client 6's needs.

#### Client 7

Review of Client 7's Client Face Sheet (undated) found Client 7 was admitted on 1/30/2009. Review of Client 7's record found documents which identified Client 7's care and treatment needs which included:

1. Nursing Assessment dated 11/7/12 identified Schizophrenia affective disorder

2. ISP dated 2/21/2017 identified fixed delusions and Schizophrenia-affective disorder. The ISP identified Client 7's therapeutic mental health interventions included staff were to remind Client 7 of the importance of attending their psychiatric and medical appointments and to ensure Client 7 saw the psychiatrist for psychotropic medication monitoring every three months.

Review of Client 7's record found no evidence Client 7 received services specific to the identified mental health needs.

Review of Client 7's Nursing Notes from 7/7/16 to 6/28/17 found Client 7 attended the Veteran's Affairs (VA) Hospital for psychiatric and medical treatment, however, Client 7 refused to attend 3 of 4 psychiatric appointments. Further review of Client 7's record found no evidence what therapeutic mental health treatment Client 7 received at the facility or VA hospital from a licensed professional who had within their scope of practice to provide psychiatric and mental health care and treatment.

Review of the therapeutic mental health groups and activities from April 2017 through July 12, 2017 found Client 7 participated in 8 out of 288 groups/activities.

Review of Client 7's Activity Progress Note, found the entry for 6/28/2017 reported, Client 7 attends group but does not participate.

Observation on 7/11/17, 7/12/17, 7/13/17 and 7/14/17 during group sessions, found Client 7 did not attend any of the groups/activities provided.

Interview with Client 7 on 7/13/2017 at 2:00pm reported they seldom attended groups as the groups were not helpful to Client 7's treatment.

#### Client 8

Review of Client 8's Client Face Sheet (undated) found Client 8 was admitted on 11/10/09. Review of Client 8's record found documents which identified Client 8's care and treatment needs:

1. Life Quest Mental Health Assessment dated 11/10/09 history of anxiety, isolation and depression.
2. Functional Assessment dated 6/20/16 occasionally remains in room and doesn't socialize.
3. Nursing Assessment dated 11/5/12 diagnosis of paranoid schizophrenia.
4. ICAP dated 8/22/12 identified a "mental illness" and Client 8 took medications for moods, anxiety, sleep, and behaviors.
5. ISP dated 6/27/17 identified a diagnosis of paranoid schizophrenia, Hepatitis C, history of drug abuse, failed independent living, non-compliance with medication, social isolation, paranoia, poor money management, poor self-image, and displayed withdrawn behavior. Client 8's ISP therapeutic mental health interventions included that the LIMHP would provide individual therapy sessions and the psychiatric APRN would monitor psychotropic medications for effectiveness and side effects every three months and as needed.

Review of Client 8's record found no evidence the facility had provided care and treatment to address Client 8's mental health needs (schizophrenia, anxiety, depression, isolating behaviors) and independent living needs identified in the documents above.

Review of Client 8's physician contact documents and Nursing Notes found Client 8 met with the psychiatric APRN on 12/27/16 and 4/11/17, which exceeded the three month period. Client 8's records found no evidence Client 8 received mental health therapy sessions from a licensed mental health professional who had within their scope of practice to provide psychiatric and mental health care and treatment.

Review of the therapeutic mental health groups and activities from April 2017 through July 12, 2017 found Client 8 participated in 7 out of 288 groups.

Review of Client 8's Activity Progress Notes from 7/28/16 through 6/28/17 found Client 7 attended groups with little to no participation.

Observations on 7/10/17, 7/11/17, 7/12/17, 7/13/17 and 7/14/17 found Client 8 did not attend the group sessions.

Interview on 7/14/17 at 10:30am Client 8 stated the facility did "nothing at all" to provide Client 8 assistance in dealing with their schizophrenia and independent living skills. Client 8 reported they did not attend therapeutic groups and activities as Client 8 had no interest in movies, coloring pictures, planting flowers, and making crafts and collages. Client 8 stated instead of going to the therapeutic groups they remained in the Annex (second residential building) cleaned, listened to music, went for bike rides, and sat outside and smoked. Client 8 made a circular motion with their hand and pointed to the door then stated "I just want out" of here.

#### Client 9

Review of Client 9's Client Face Sheet (undated) found Client 9 was admitted 1/14/09. Review of Client 9's record found documents which identified Client 9's care and treatment needs:

1. Life Quest Mental Health Assessment dated 2/5/09 the reason for admission was left blank.
2. Functional Assessment dated 8/22/16: sends out laundry, has a trustee/payee, utilized walker with assistive devices, required nursing services and medication administration, and forgetfulness.
3. ISP dated 2/22/17: diagnosed with Bi-Polar, Schizoaffective Disorder-delusional behavior, resistive to medications, failed independent living situations, difficulty with roommates, feelings kept to self, chronic and persistent mental illness. Client 9's identified therapeutic mental health interventions included staff encouraging Client 9 to participate in self-help groups daily, individual therapy with the LIMHP on a monthly and as needed, and meet every three months with the psychiatric APRN who monitored Client 9's psychotropic medications for effectiveness and side effects.

Review of Client 9's record found no evidence the facility provided care and treatment to address Client 9's mental health issues (Bi-polar, schizophrenic, delusional behaviors), and independent living skills.

Review of Client 9's record and Nursing Notes dated 5/25/17 through 6/9/17/17 found no evidence of monthly therapy sessions with a licensed professional who had within their scope of practice to provide psychiatric and mental health care and treatment. Further review of the Nursing Notes and the

psychiatric physician contact documents found the facility did not ensure Client was evaluated every three months.

Review of the facility's therapeutic group activity calendar and attendance documents from April 2017 through July 12, 2017 found Client 9 attended in 138 out of 288 groups.

During an interview on 7/12/17 at 8:52am, Client 9 reported they enjoyed groups however their medications make Client 9 too tired to attend so they stayed in their bedroom.

#### Client 10

Review of Client 10's Client Face Sheet (undated) found Client 10 was admitted 4/30/08. Review of Client 10's record found documents which identified Client 10's care and treatment needs:

1. Practitioner's Appointment Sheet dated 2/15/17: diagnosed with Schizophrenia and Mild MR
2. Life Quest Mental Health Assessment dated 6/17/08: admitted for "failed placement at home and other facility" and history suicidal ideations (two attempts) and homicidal ideations.
3. Richard Young Hospital Inpatient Initial Pysch Evaluation dated 1/15/16: history of schizoaffective disorder; suicidal ideations with an attempted plan to use a knife to cut self and stated wanted to be dead
4. Nursing Assessment dated 9/24/12: history of suicidal attempts.
5. Functional Assessment dated 6/14/16: forgetfulness, remains in room/doesn't socialize, and always/continuously uses foul language, angry/threatening to others, and required assistance with housekeeping and finances.
6. ISP dated 5/23/17: diagnosed with Schizophrenia, poor anger and impulse control, unresolved grief, poor relationship and social skills. Client 10's therapeutic mental health interventions included the LIMHP was to provide 1:1 therapy for coping skills and relaxation techniques twice a month, monthly monitoring of psychotropic medications by the psychiatric APRN, and Client 10's participate in therapeutic groups and activities three times per week.

Review of Client 10's record found no evidence the facility provided care and treatment or addressed with Client 10 how to manage Client 10's suicidal and homicidal ideations, anxiety, and aggressive and threatening behaviors identified above.

Review of Client 10's psychiatric evaluation/management document from 10/11/16 to 7/13/17 found Client 10 attended 5 of 10 monthly therapy sessions. The ISP identified Client 10 was to meet monthly with the psychiatric APRN. The documents identified dates attending as 10/11/16, 1/10/17, 3/28/17, 4/25/17, and 6/13/17.

Review of Client 10's Nursing Notes from 2/14/17 until 7/13/17 found no evidence Client 10 received monthly 1:1 therapy and treatment from the LIMHP or another licensed mental health professional who had within their scope of practice to provide psychiatric and mental health care and treatment.

Review of the facility's therapeutic group activity calendar and attendance documents from April 2017 through July 12, 2017 found Client 10 attended 26 out of 288 groups.

Interviews on 7/10/17 at 6:00pm and 7/12/17 at 11:41am, Client 10 reported the facility provided no therapeutic treatment or supports to meet Client 10's mental health, independent daily cares, and self-medication administration needs. Client 10 stated they did not attend or participate in therapeutic groups and activities because "I think it's a joke" and the groups were "bullshit" and dealt with "petty things." Client 10 reported groups included the same topics of anger management, depression, movies, playing games, and coloring pictures which didn't help Client 10 be more independent. Client 10 reported their treatment consisted of psychiatric medication reviews and attending 1:1 counseling with the LIMHP for anger management and grief/loss issues. Client 10 stated "I've got the tools" to move out and live independently in the community but the facility would not allow Client 10 to move out. Client 10 stated they taught them self how to control their anger by counting down from ten to one, listening to music, taking deep breaths, and keeping their room clean.

In an interview on 7/13/17 at 2:40pm, the Administrator/RN reported Client 10 had unresolved grief/loss issues related to the death two relatives within the last two years that impact his behaviors. Client 10 saw the LIMHP for individual counseling related to grief and anger. The Administrator/RN stated Client 10 wanted to move out and live independently so Client 10 was working with their guardian to complete housing applications and find other treatment options in the community.

Additional record review and interviews found the following clients did not regularly attend or participate in the facility's groups and activities.

#### Client 21

In interviews on 7/10/17 at 3:55pm, Client 21 reported they sometimes attended the therapeutic groups. Therapeutic groups were from 9:30am until 11:00am Monday through Friday and nothing on the weekends. Client 21 stated therapeutic groups addressed how to: control anger, deal with coping skills, and mental illness. Client 21 reported Staff B conducted the therapeutic groups and would give clients worksheets for topics like anger control that broke down how to address feelings and dealing with anger. Client 21 stated attendance at therapeutic groups varied from a few people up to thirty depending on the topic.

Review of the facility's therapeutic group activity calendar and attendance documents from April 2017 through July 12, 2017 found Client 21 attended 52 out of 288 groups.

#### Client 24

During an interview on 7/11/17 at 8:15am Client 24 reported meeting with their attorney to become their own guardian so that Client 24 could make their own decisions and move out of the facility. Client 24 stated they received medical and counseling therapy services through the Veteran's Association (VA) hospital as the facility did nothing to provide mental health treatment or teach independent living skills. Client 24 planned to move out of the facility, purchase or rent a modular home in Grand Island, and continue to receive the mental health and medical services at the VA hospital. Client 24 reported they had created a budget with their attorney and would be able to pay their bills and personal expenses. In an addition interview on 7/13/17 at 9:05am, Client 24 reported feeling pressured by the facility to attend groups and to clean their bedroom and bathroom at the same time, which was too much to deal

with today. Client 24 also reported the facility provided no staff supervision, staff pushed their authority to get clients to comply, and the facility needed a security guard.

Review of the facility's therapeutic group activity calendar and attendance documents from April 2017 through July 12, 2017 found Client 21 participated in 20 of 288 groups.

Review of Client 24's Activity Progress Notes from 6/28/16 through 6/28/17 identified Client 24 attended group with little participation, listens well but not much participation, and attends group and participates.

In an interview on 7/14/17 11:20am, the LPN reported Client 24 received therapy and counseling services from the Social Worker and Therapists at the local VA hospital. The VA gave Client 24 therapy assignments to work to improve relationship building, health and anger management. The LPN stated in their opinion Client 24's mental health issues were related to jealousy which caused Client 24 to become anxious and depressed. The LPN reported when Client 24 asked for their PRN psychotropic medications, as Client 24 did on 7/13/17, it was an indicator Client 24 was currently depressed. The LPN provided no information how or what supports the facility provided Client 24 to address their current depression and mental health needs.

#### Client 50

Interviews on 7/10/17 at 6:00pm Client 50 reported not attending therapeutic groups or activities as sessions included getting a coloring sheet and crayons, flash cards, and/or worksheets about schizophrenia. Client 50 stated "stupid shit like that's not group therapy" and did not help Client 50. Client 50 stated they learned how to cope and deal with their schizoaffective disorder on their own.

Review of the facility's therapeutic group activity calendar and attendance documents from April 2017 through July 12, 2017 found Client 50 attended 4 of 288 therapeutic mental health groups and daily care activities.

Observations on 7/10/17, 7/11/17, 7/12/17, 7/13/17 and 7/14/17 found Client 50 did not attend the group sessions.

- B.** The facility failed to conduct assessments and provide the necessary medical care and treatment oversight to meet client needs

Review of the facility's Program Description (dated 4/1/13) found the RN was on-call 24 hours a day for direction and monitoring; the LPN would assist with medical issues, treatments, or medical appointments, and follow-up care; the facility staff was to monitor client health conditions and report any changes in condition to the client's physician; and nursing staff monitored client health conditions and was to seek medical attention when warranted.

Review of the policy titled "Regular Health Screening" (undated) found the facility's staff would provide close monitoring and reporting to client's physicians.



### Client 1

Review of Client 1's record found Client 1 had been at the facility for four years. Review of Client 1's Face Sheet identified Client 1 was diagnosed with chronic pain, cerebral embolism, atrial fibrillation and osteoarthritis. Review of the Medication Self-Administration Assessment found Client 1 refused to take any medications so the facility had the doctor discontinue all medications on 11/26/12. Review of the 11/12/12 Physician Communication Sheet identified Client 1 refused all medications upon admission on 7/10/12 to the facility.

However, there was no evidence the facility had completed or referred Client 1 to a physician for an assessment to determine a treatment plan that addressed and provided medical oversight of Client 1's medical care, chronic pain, osteoarthritis, and atrial fibrillation.

### Client 3

Observations on 7/10/17 at 2:05pm and 2:18pm found Client 3 talked with Staff A in hallway in front of the office door, however Client 3 moved constantly, paced back and forth, and their hands, arms, and head made uncontrolled jerky, shaking, and twitching movements as Client 3 reported not sleeping and other issues.

Review of the Mary Lanning Health Care Continuity of Care document dated 6/6/17 identified Client 3 was diagnosed with psychotropic disorders secondary to Huntington's disease and hypertension.

Review of document titled Hansen Medical, PC: Visit Note--Transition of Care dated 7/3/17 identified Client 3 had Huntington's disease and hypertension (HTN). Client 3 was referred to a neurologist for further follow-up with their Huntington's disease. Client 3 was prescribed Tetrabenzine 12.5mg for Huntington's disease; Citalopram discontinued due to interactions with the Tetrabenzine; and Zoloft 50mg prescribed in exchange.

Review of the Client 3's July 2017 MAR (provided by the facility on 7/12/17) did not include Tetrabenzine as per the 7/3/17 physician's order. The July 2017 MAR identified Client 3 continued to receive Citalopram 10mg at 8:00am from 7/1/17 to 7/12/17 and Sertraline 50mg from 7/4/17 to 7/12/17.

Review of Client 3's record found no evidence the facility had assessed, developed or implemented a plan, and/or provided care and treatment supports to address Client 3's Huntington's disease and hypertension.

Review of the Nurse's notes dated 7/3/17 found Staff C documented that Client 3 had been prescribed a new medication and the physician wants him to see a neurologist they will make appt. However, Client 3's record contained no evidence of follow-up or occurrence of the neurological appointment.

### Client 5

Review of Client 5's medical record found Client 5 has been diagnosed with Bilateral Cataracts, Arthritis, Asthma, Emphysema and COPD.

Review of Client 5's July Medication Administration record (MAR) found two prescribed medications one for allergy symptoms and one for asthma symptoms. Besides medication provision there was no evidence provided as to how the facility was supporting or monitoring Client 5's other medical issues regarding Arthritis and bilateral cataracts.

#### Client 6

Review of Client 6's medical record found Client 6 has been diagnosed with Dementia, Alcohol Dependence and COPD.

Review of Client 6's July MAR found they were on medications for bacterial infections in regards to lung disease, hypertension, sleep disorder, joint pain and swelling. Besides medication provision, there was no evidence provided as to how the facility was supporting Client 6 with their medical issues.

Interview with Client 6 on 7/12/2017 at 11:05am and 7/14/2017 at 10:30am found Client 6 was in pain daily from hip surgery. Client 6 also reported they had been originally diagnosed with lung cancer, which was later changed to tuberculosis which was most recently changed again to Mycobacterium avium complex or MAC, a cousin to tuberculosis. In addition, Client 6 stated they had also been diagnosed with dementia. To their knowledge there had been no medical supports provided for the Dementia or memory loss Client 6 had been experiencing. Client 6 stated the Medication Aides provided Client 6 with their medications, but there really were no other supports provided for the medical issues Client 6 dealt with every day.

#### Client 7

Interview with Client 7 on 7/13/2017 at 2:00pm, Client 7 reported they lived at the facility for eight years. Client 7 reported they currently suffered from ulcers, stomach issues, vomiting, and had diarrhea daily as a result of their diabetes and COPD.

Review of Client 7's medical record found Client 7 received medical and mental health supports from the Veteran's Affairs hospital (VA). Client 7's had a medical diagnosis of COPD, Vitamin D deficiency, and Diabetes.

Review of Client 7's Nursing Notes dated 3/10/16 to 12/20/16 found Client 7 had a history of refusing to go to scheduled appointments with the VA.

Review of Client 7's July MAR found they took medications for High Blood Pressure, Constipation, Depression, Blood sugar control, Nausea, ulcerative colitis, diabetes and emphysema. Besides medication provision, there was no evidence provided in Client 7's record as to how the facility was supporting Client 7 with their medical issues.

#### **C. The facility failed to establish and implement measures to address medication refusals**

Review of the Licensed Practical Nurses' (LPN) job description titled "LPN Job Description Life Quest" (undated) identified the RN was responsible for oversight of the medication administration record (MAR) and reporting medication refusals the client's physician in a timely manner.

Review of the MARs found medication refusals were indicated by a circle around the initials of the medication aide or nurse providing the medications and refusal documented on the last page of the MAR.

In an interview on 7/11/17 at 8:12am Staff A reported it was client's choice to take or refuse medications. Staff A stated refusals were documented on the MAR. When asked if teaching occurred when a medications were refused, Staff A replied the medication wasn't provided and nothing else happened.

Observations of medication passes on 7/10/17 at 3:00pm, 7/11/17 at 7:10am and 7/12/17 at 8:05am found Staff A (a medication aide) routinely asked clients when they came to the medication room door if they wanted all of their medications. If the client replied no, Staff A would ask which medications the client didn't want to take, then did not provide the medication and documented the refusal on the MAR.

However, record review found no evidence the facility: 1) notified the client's physician regarding medication refusals; and 2) identified care and treatment interventions to address medication refusals for the following clients.

#### Client 2

Review of Client 2's 3/21/17 ISP, 3/20/17 Discharge Plan, 9/22/16 Medication Self-Administration Assessment record found Client 2 had a history of medication non-compliance, refusal, and being unable to self-administer medications.

Review of Client 2's 3/21/17 ISP "Medication" section identified staff monitored the administration of Client 2's medications, however the ISP identified no teaching or interventions regarding Client 2's refusals and medication compliance.

Review of Client 2's MAR from July 1 to 12, 2017 found 9 instances of refused medication for Client 2's Linzess and SF Gel. However, review of Client 2's record found no evidence these refusals were reported to Client 2's physician.

#### Client 6

Review of Client 6's ISP dated 5/23/17 found Client 6 had a history of medication non-compliance and refusal. The ISP contained no teaching or interventions to address Client 6's non-compliance and refusal of medications.

Review of Client 6's MAR from June 2017 found 20 instances of Client 6 non-compliance with medication provision of three prescribed medications and for July 1 to 12, 2017 found 18 instances of medications identified as "refused" for Client 6's Proventil AER/HFA inhaler, Thera-M vitamin, Trifluoperaz tab, Fluticasone nasal spray, and Spiriva inhaler. Review of Client 6's record found no evidence these refusals were reported to Client 6's physician.

### Client 9

Review of Client 9's MAR from July 1 to 12, 2017 found 14 instances of "refused" medications for Client 9's Polyeth-Glycol powder and Ensure supplement. Review of Client 9's record found no evidence these refusals were reported to Client 9's physician.

Review of Client 9's record found no evidence that identified Client 9 refused to take medications as prescribed.

### Client 10

Review of Client 10's 5/23/17 ISP, 11/12/16 Medication Self-Administration Assessment found a history of medication non-compliance, not taking medications timely and refusal.

Review of Client 10's MARs (medication administration records) from July 1 to 12, 2017 found one instance on July 4, 2017 in which Client 10 refused all of the morning medications which included Hydrochloroto tab, Prednisone, Symbicort, Klor-Con 8, Levothyroxin, One-Daily vitamin, Fiber tab, Gemfibrozil, Zipriasidone, Quetiapine, Diazepam, Fluticasone nasal spray, Strattera and Deep sea spray. Additional review of Client 10's record found no evidence the refusals were reported to Client 10's physician.

**D.** Record review and interviews found no evidence the facility assisted in obtaining the necessary alcohol and/or drug treatment.

Review of the facility policy titled "Life Quest Mental Health Center Program Description" dated 4/1/13 found the facility offered an Adult Day Program activities which included AA/NA (Alcoholics Anonymous/Narcotics Anonymous) supports.

Review of the facility therapeutic activity calendars from April 2017 to July 2017 found every Wednesday at 11:00am the facility scheduled AA meetings (15 total). However, review of the activity attendance records for April 2017 to July 12, 2017 found no evidence clients attended the AA meetings. In addition, the facility provided no evidence of other types of support provided regarding alcohol or drug treatment.

In an interview on 7/14/17 at 3:30pm Staff B reported the facility offered to take clients to AA meetings in another city. Clients were responsible to sign-up to attend AA. The facility would transport only if a minimum four or five clients signed up to attend. Staff B stated in group sessions they used workbook activities to review substance abuse issues. Staff B stated as a recovering drug addict themselves, they would occasionally meet with a couple of clients and discussed the AA 12-step program. Staff B stated they believed the facility and clients would benefit from having another counselor/therapist onsite for clients to talk about addictions.

Record review and interviews found the facility did not provide referrals or assisting client to obtain care and treatment for alcohol and/or drug use and abuse for the following clients.

### Client 2:

Review of Client 2's record found the following documents identified Client 2's history of alcohol and drug use:

1. Life Quest Mental Health Assessment dated 9/14/15, history of medication overdose (suicidal attempt), alcohol and methamphetamines use as coping mechanism.
2. ISP dated 3/21/17, history of methamphetamine use.

Review of Client 2's record found no evidence the facility had completed an alcohol and/or drug assessment to determine what supports or referrals Client 2 required as part of their care and treatment. Review of Client 2's record and 3/21/17 ISP found no goals or interventions to address Client 2's history of alcohol and drug use.

During an interview on 7/11/17 at 8:25am Client 2 reported they had used alcohol and methamphetamines to cope with their anxiety and mental illness. Client 2 stated the facility provided no care and treatment supports and had not referred Client 2 for drug and alcohol therapy. Client 2 reported they did not attend Alcoholics Anonymous (AA) meetings.

### Client 5

Review of Client 5's record found the following documents identified Client 5's history of alcohol abuse:

1. ISP dated 2/21/17, history of alcohol abuse.
2. Life Quest Mental Health Assessment dated 8/17/16, addiction and history of alcohol abuse and tobacco use.

Review of Client 5's record found the facility failed to assess Client 5's history of alcohol abuse and determine what referrals or additional treatment supports Client 5 needed. Additional reviews of Client 5's ISP and record found no evidence of interventions, referrals, or how the facility was treating Client 5's specific alcohol abuse needs besides the activities offered on the facility groups/activity calendar.

### Client 6

Review of the following documents found in Client 6's record identified Client 6's history of alcohol and drug use:

1. Evaluation/Monitoring (E/M) document from the Psychiatric APRN dated 6/27/17, identified a current diagnosis of Alcohol Use Disorder, in early remission, in a controlled environment; Severe.
2. ISP dated 5/23/17, alcohol dependence
3. Resident Admission and Discharge Record dated 4/14/14, alcohol dependence
4. Discharge Plan dated 5/22/17, alcohol dependence and referrals would need to be made at the time of discharge for these issues.

Review of Client 6's record found no evidence the facility assessed Client 6's alcohol abuse to determine what supports or referrals Client 6 required as part of their care and treatment. Client 6's ISP did not include interventions to address Client 6's alcohol abuse. Besides the activities identified on facility's Groups Calendar identified above, there was no evidence Client 6's Alcohol Dependence was being treated by the facility.

Interview with Client 6 on 7/14/2017 at 10:30am found Client 6 reported being an alcoholic and was aware how alcohol reacted with Client 6's current medications. Client 6 stated their medications were the biggest deterrent to using alcohol, as it could be "deadly combination." Client 6 stated they had been drinking on the night of July 1, 2017 at a street dance in the community and had returned to the facility drunk. According to Client 6, upon their return to the facility Staff K had been unprofessional and rude, so Client 6 threatened to harm Staff K. As a result, Staff K called their spouse who came to the facility and was rude to Client 6.

#### Client 10

Review of the following documents found in Client 10's record identified Client 10's history of alcohol and drug use:

1. ISP dated 5/23/17, history of Drug and Alcohol Abuse.
2. Practitioner's Appointment Sheet dated 2/15/17, Drug Abuse and Alcohol Abuse
3. Richard Young Hospital Inpatient Initial Psych. Evaluation dated 1/15/16 stated admission and previous hospital records found Client 10 had an alcohol and drug abuse history prior to residing at the Life Quest facility.
4. Nursing Assessment dated 9/24/12, History of Drug and Alcohol abuse.
5. The Life Quest Mental Health Assessment dated 6/17/08, prior to admission Client 10 was hospitalized for chemical dependency (no date), arrested for driving while intoxicated resulted in serving a jail sentence, and Client 10 "tried to kill himself by drug overdose."

Review of Client 10's record found no evidence the facility had completed an alcohol and/or drug assessment to determine what supports or referrals Client 10 needed for alcohol and drug treatment.

Review of Client 10's 5/23/17 ISP did not include goals or interventions to address Client 10's history of alcohol and drug abuse. The 5/23/17 ISP identified Client 10 "has stayed sober and drug free while been a resident here."

However review of Client 10's record found on 7/18/16 the LPN submitted a document to Client 10's general practitioner which stated, "On July 15<sup>th</sup>, 2016 the above resident [Client 10] was caught attempting to smoke marijuana" and the facility removed and disposed of marijuana and drug paraphernalia in Client 10's possession. Further review of Client 10's record found no follow up documentation as to what the facility did to refer or provide care and treatment supports to Client 10 based on this incident.

During an interview on 7/10/17 at 6:00pm Client 10 stated they had a history of drug and alcohol abuse. Client 10 reported since their admission (4/30/2008) the facility provided no care and treatment supports to address Client 10's alcohol and drug use. Client 10 reported the facility provided transport to AA meetings in Grand Island, NE; however, Client 10 has not attended an AA meeting for more than four weeks as not enough clients sign-up for transport to attend the AA meetings so the facility did not take Client 10 to the meetings.

### Client 21

In an interview on 7/10/17 at 3:55pm, Client 21 reported a history of alcohol use and had learned how to treat their alcoholism on their own. Client 21 reported they received treatment for their alcoholism by attending AA meetings in Grand Island, NE. However Client 21 reported they had not been to a meeting for more than three or four weeks as the facility did not provide transportation to AA if less than four clients signed up for transportation. Client 21 reported the facility provided no other treatment options during this time.

### Client 50

In an interview on 7/10/17 at 6:00pm, Client 50 reported they had a history of alcohol use. Client 50 stated the facility did not provide, assist, or refer clients to other sources for care and treatment of alcohol use. Client 50 stated they addressed their own treatment by reading an AA book. Client 50 reported the facility offered to transport clients to AA meetings; however, Client 50 had not been to a meeting for more than four weeks because not enough clients had not signed up for transport to attend the AA meetings.

- E. The facility failed to provide care and treatment to meet clients identified assistive supports, personal hygiene, clothing choices, laundry, and appropriate beds:

Review of the facility's Program Description (dated 4/1/13) identified clients admitted to the facility must demonstrate the ability to care for their own personal hygiene needs.

Review of the facility job description titled Direct Support/Med Aide (undated) found facility staff were expected to assist clients with addressing ISP goals, monitor cleanliness, and supervise clients that needed assistance with laundry and cleaning.

Interview with Staff A on 6/8/2017 at 3:43pm stated they did not know they were to be assisting clients with cleaning their rooms, hygiene, or laundry needs.

### Client 1

Review of Client 1's Face Sheet (undated) found Client 1 was admitted 7/10/12. Review of Client 1's record found the following documents identified Client 1's care and treatment needs:

1. Life Quest Mental Health Assessment dated 7/10/12: Daily living skills: reminders to clean self, and hoards items.
2. Functional Assessment dated 7/18/16: requires preparation of bathing articles (soap, towels, washcloth), able to wash self at sink, needs reminders for hygiene/grooming, and laundry must be done by staff to ensure Client 1 wears clean clothing.

Observation while onsite on 6/6/17, 6/7/17, 6/8/17, 6/9/17, 7/10/17, 7/11/17, 7/12/17, 7/13/17, and 7/14/17 found Client 1 did not leave their bedroom to complete personal hygiene, laundry, or attend meals. Client 1 did leave briefly on 6/8/17 and 7/13/17 to receive their spending money which Client 1's clothing was unkempt, grimy, and wrinkled.

Interview with the LPN on 7/14/17 at 1:30pm found Client 1 did not use the communal/public showers as Client 1 bathed at the sink in their bedroom.

Interview with Client 44 on 7/11/17 at 2:54am reported Client 1 stayed in their room all the time did not come out of their room to shower.

Further review of Client 1's record found no evidence or plan to address or teach Client 1 skills in daily living and personal hygiene.

#### Client 2

Observations on 7/10/17, 7/11/17, and 7/13/17 found Client 2's appearance to be unkempt. Client 2 wore the same lounge/pajama pants or gray sweatpants, baggy and worn-out t-shirts that appeared to be white or pale colored but were dingy gray in color now, and interchanged a gray sweatshirt with a red sweatshirt every two days. Client 2's hair was either uncombed and matted to their head (like they'd slept on their side) or had an oily and frizzy appearance.

Review of Client 2's Life Quest Mental Health Assessment (dated 9/14/15) and Functional Assessment (dated 3/28/16) identified Client 2 had daily living treatment needs regarding personal hygiene/grooming, bathing/showering, ensuring laundry is completed, personal shopping, budgeting, and completing basic environment cleaning.

In an interview on 7/10/17 Client 2 stated they did not shower daily, tried to shower every couple of days, and needed to get better at showering and personal hygiene.

Further review of Client 2's record found no evidence or plan to address or teach Client 2 skills in daily living and personal hygiene.

#### Client 3

Review of hospital discharge records dated 5/17/17 through 6/6/17 found Client 3 needed reminders to complete personal hygiene.

Review of Client 3's Life Quest Mental Health Assessment dated 6/22/17 identified Client 3 could no longer live independently as they needed assistance with laundry, shopping, budgeting, transportation, meal planning, and taking medication on time.

Review of Client 3's Functional Assessment dated 6/21/17 identified Client 3 needed reminders and assistance to bathe, shave, comb hair, brush teeth, do personal shopping, to complete housekeeping, and laundry. Client 3 required a trustee/payee for finances and complete supervision and administration of medications. Client 3 could cook hot meals but needs prompting and assistance with using kitchen.

Further review of Client 3's record found no evidence or plan to address or teach Client 3 skills in independent living and personal hygiene.

#### Client 4



Observations on 7/12/17, 7/13/17 and 7/14/17 found Client 4 wore the same faded black t-shirt and faded black jeans. Client 4's t-shirt had a few dime to quarter sized dark marks on the front and the jeans were dingy and had dark streaks on the thighs.

Interview of Client 4 on 7/14/17 at 11:50am reported needing staff to remind Client 4 to take a shower, comb their hair, and change their clothes.

Review of Life Quest Mental Health Assessment dated 11/30/03 and 5/13/05 identified Client 4 had a disheveled appearance resulting in Client 4 requiring reminders to shower, change clothing, and complete personal hygiene/grooming.

Review of Client 4's Functional Assessment (dated 5/23/16) found the facility determined Client 4 is independent with bathing, hygiene, dressing, and was capable to do their own laundry.

However, review of the Mid Plains Center for Behavioral HealthCare Services, Inc., Evaluation/Monitoring (E/M) Document (dated 5/9/17) completed by the psychiatric APRN identified Client 4's goals included maintaining personal hygiene and grooming.

Further review of Client 4's record found no evidence or plan to address or teach Client 4 good hygiene and grooming skills.

#### Client 5

Observations on 7/10/17, 7/11/17, 7/12/17, and 7/13/17 at 12:08pm found Client 5 wore the same black t-shirt with an Americana flag design, dark colored jacket, and blue jeans. The jacket and jeans were dingy and had black streaks, the black t-shirt had dime sized dark spots and a few white streaks ranging from about one-quarter inch to one inch in length. Client 5's hair was unkempt and had an oily and dingy appearance.

Review of Client 5's Functional Assessment dated 8/4/2016 found Client 5 needed minor assistance/reminders to bathe, shave, comb hair, clip nails, brush teeth, housekeeping, laundry, and food preparation.

Review of Client 5's ISP dated 7/29/2016 found Client 5 needed assistance with personal hygiene.

Review of Client 5's Discharge plan dated 2/21/2017 identified that upon discharge Client 5 would need assistance with cleaning/housekeeping and laundry.

Further review of Client 5's record found no evidence or plan to address or teach Client 5 skills in daily living and personal hygiene.

#### Client 6

Observations on 7/10/17, 7/11/17, and 7/12/17 at 8:12am found Client 6 wore the same black jeans and red colored t-shirt over a black long sleeved t-shirt. Client 6's jeans had dark colored streaks on the thigh area and the red t-shirt had a few smaller circular dark spots. Client 6 wore a baseball style hat, however

Client 6's hair that showed beneath the baseball hat was straight, had a stringy, oily, and grease-like appearance.

Review of Client 6's Functional Assessment dated 5/23/2016 found Client 6 needed assistance with food preparation and housekeeping.

Review of Client 6's ISP dated 5/23/2017 found Client 6 had forgetfulness issues due to a diagnosis of dementia and would need reminders for self-cares.

Review of Client 6's Discharge plan dated 5/22/2017 identified that upon discharge Client 6 would need assistance with cleaning/housekeeping and laundry.

Further review of Client 6's record found no evidence or plan to address or teach Client 6 skills in daily living and personal hygiene.

#### Client 15

Observations on 7/10/17, 7/11/17, 7/12/17 at 8:12am, and 7/13/17 at 12:08pm found Client 15 wore the same gray colored t-shirt and light colored jeans each day. Client 15's appearance was unkempt and their clothes were wrinkled, had small brown and black spots on the t-shirt front, and dingy black streaks on the front and hem of the jeans. Client 15's hair was unkempt, matted, greasy, and hung in clumps around their face and neck. Client 15's fingernails had an orange and yellow tint and black substance under the nails. Client 15 had a strong, stale, and smoky smelling odor.

#### Client 34

Observations on 7/10/17, 7/11/17, 7/12/17 at 9:00am, and 7/13/17 11:30am found Client 34 was unkempt and wore the same black shorts and hot pink colored long sleeved t-shirt. Client 34's pink t-shirt had a three to four inch streak of yellow substance down the front and their shorts had white splatter marks on the front. Client 34's shirt and shorts had remnants of food from meals over the course of the 4 days. Client 34's hair was greasy, matted, hung in Client 34's face and eyes, and the top of Client 34's hands and fingers had a brown-orange hue.

#### Client 32

Observations on 7/11/17, 7/12/17, and 7/13/17 12:08pm found Client 32 wore the same white t-shirt and dark navy blue jogging pants. Client 32's t-shirt had two dime sized brown spot on the front and the jogging pants had black streaks on the front that were one to two inches in length.

#### Client 39

Observations found on 7/10/17, 7/11/17, and 7/12/17 found Client 39 was unkempt and wore the same bibbed jean overalls and gray and navy blue plaid long sleeved shirt. Client 39's bibbed overalls had dark colored streaks about two to three inches in length on the front thigh area.

#### Client 48

Observations on 7/11/17 and 7/12/17 at 8:12am found Client 48 wore the same pink shorts and printed yellow-pink-teal colored tank top that were wrinkled and had six spots and splatter nickel sized marks. Client 48's appearance was unkempt and their hair was matted and flat to the back of their head.

#### Client 50

Observations on 7/12/17, 7/13/17, and 7/14/17 at 11:05am, found Client 50 wore the same camouflaged shorts and gray t-shirt. Client 50's t-shirt had dime to quarter sized dark spots on the chest. Client 50's shorts were wrinkled and had dark streaks and splatter marks. Client 50's was unkempt, their hair not combed and had a greasy/oily appearance, and had body odor.

#### Client 30

Observation on 7/14/17 at 10:46am found Client 30 stood in the hallway (next to their bedroom) with their walker. Client 30 walked into the bedroom and identified the location of their bed. Observation of Client 30's bed found two mattresses stacked on top of each other, was about three foot tall, and had no box springs. Client 30 had a short stature (about 5'4" tall) and utilized a walker for mobility for long distances. Further observations of Client 30's bedroom found the bathroom had no grab bars to assist Client 30.

In an interview during the observation on 7/14/17 at 10:46am, Client 3 reported they slept in their chair/recliner instead of their bed. The bed was so high off the ground and Client 30 was unable to get up on to the bed. Client 30 reported it would be nice to have grab bars next to the toilet to assist with standing.

**F.** The facility failed to make provisions for adequate food to meet client needs.

1. Failure to provide adequate food to meet client diet needs.

Review of the policy titled "Nutrition" (no date) identified all clients received regular diets with the exception of diabetic clients.

Review of the policy titled "Life Quest Mental Health Center Program Description" dated 4/1/13 found the facility would meet client dietary needs and work with client's Physician or a Nutritionist to ensure client dietary needs were met.

Interviews on 7/14/17 at 11:20am and 1:10pm the LPN reported the facility had no clients receiving specialized diets. The LPN stated if a client had a diet order from their physician, the facility would request the doctor "re-write the order" as the facility prepared and served the same meal to all clients. The LPN reported the facility provided milk substitutes to client that were lactose intolerant or did not like milk and offered diabetic clients sugar-free syrups and jellies. When showed the Program Description regarding dietary needs, the LPN stated "it's always been" facility practice that the facility did not accommodate or prepare separate meals to meet client specialized diets.

In an interview on 7/11/17 at 2:40pm, the Administrator/RN reported the facility did not employ or contract with a dietician or nutritionist to evaluate client dietary needs. The Administrator/RN reported Staff G was the cook for the facility and prepared the same meals for all clients.

Interview with Staff G (facility cook) on 7/11/2017 at 12:10pm stated the same exact meal was prepared and served to all the clients.

Observations during meal times found the facility served the same foods to all clients at the following meals:

7/10/17: Supper-Ham and cheese hoagie sandwich, potato chips, Jell-O-fluff salad, and glass of milk;

7/11/17: Breakfast-cold cereal, toast, coffee, milk, or juice; Lunch-fried chicken, corn on the cobb, Jell-O salad, mashed potatoes and gravy;

7/12/17: Breakfast-pancakes, eggs, little Smokey sausages, and milk; Lunch- meatloaf, corn, bread, cherries, and vanilla pudding; Supper-Tuna/Egg Salad sandwich, chips, pears, and chocolate cake with frosting

7/13/17: Lunch-Taco salad, Spanish rice, and a churro stick

7/14/17: Lunch-chicken fingers, French fries, salad, and dessert

#### Client 21

During an interviews on 7/10/17 at 4:55pm and 5:10pm, Client 21 reported they were to receive a “cardiac diet” (no cholesterol or fats) due to the heart surgery Client 21 had in October 2016. Client 21 reported they received the same meals as all of the other clients. Client 21 stated they did not eat the supper meal as they did not like the food and the food was not healthy for Client 21 to eat.

Review of Client 21’s cardiac rehabilitation discharge report (dated 10/28/16) found Client 21 was discharged with a “low fat/cholesterol” diet. Further review found Client 21’s discharge orders were signed and “noted 10/28” by the LPN as received. Client 21’s record contained no evidence from Client 21’s physicians identifying this diet order was not valid.

In interviews conducted on 7/14/17 at 11:20am and 1:10pm, the LPN stated Client 21 had heart surgery in October 2016, however the LPN was not aware Client 21 had a special diet order. The LPN reported after reviewing Client 21’s 10/28/16 cardiac rehabilitation discharge documents, the LPN found Client 21 was discharged back to the facility with a low fat and cholesterol diet. The LPN stated they did not clarify the order with Client 21’s primary or cardiac physicians and no other diet orders existed in Client 21’s record changing or canceling the low fat and cholesterol diet.

#### Client 7

Observation of Client 7’s bedroom on 7/13/2017 at 2:00pm found Client 7 had 12 packs of regular Dr. Pepper in their bedroom. Interview with Client 7 during the observation, found Client 7 was an insulin dependent diabetic. In addition Client 7 reported they have stomach ulcers and that Client 7 throws up and has diarrhea daily. Client 7 stated meals were prepared for all clients regardless of dietary issues. During the interview Client 44 brought Client 7 a pre-packaged sandwich from the community. Client 7 stated they had been unable to eat the meal prepared (at the facility) for lunch due to their stomach. Client 7 stated they asked peers to get food for Client 7 from “uptown” many times during the week.

Review of Client 7's record found Client 7 was diagnosed with type-2 diabetes and had a Vitamin D deficiency. Review of Client 7's July 2017 MAR identified Client 7 received Mesalamine for ulcerative colitis and Omeprazole for stomach and esophagus issues. Further review, found no evidence the facility had assessed or made accommodations to meet Client 7's dietary needs. There was no evidence found in the client record the facility was monitoring or providing assistance to Client 7 in dietary management of their diabetes.

***19-006.11 Mental Health Services: The facility must arrange for access to mental health services on a routine and ongoing basis to meet the identified client needs. The facility must assist the client in keeping appointments and participating in treatment programs.***

***19-006.11A Professional Services: The facility must arrange for licensed mental health professional services consistent to meet client population served and individual client needs on an ongoing basis.***

***19-006.11B Emergency Services: The facility must make arrangements for care of client emergencies on a 24 hour, 7 day a week basis. Arrangements must include the following:***

- 1. Access to qualified facility staff trained to handle psychiatric behaviors who must be available to provide care and treatment;**
- 2. Plan for provision of emergency treatment, including circumstances when restraint use may be necessary and how facility staff will respond; and**
- 3. Plan to provide safety to clients who pose an imminent danger to themselves or others, which may include transfer to an appropriate facility.**

This standard is not met as evidenced by:

Based on record review and interview the facility failed to ensure clients with identified therapeutic mental health needs had access to routine and ongoing mental health services. This affected 10 of 10 sampled clients and 2 additional clients reviewed (Client 1, Client 2, Client 3, Client 4, Client 5, Client 6, Client 7, Client 8, Client 9, Client 10, Client 21, and Client 50). This had the potential to affect other clients at the facility.

Findings:

A. Failure to provide access to routine and on-going mental health services.

Review of the facility policy titled "Life Quest Mental Health Center Program Description" dated 4/1/13 found the facility would provide care and treatment to promote and enhance the individualized needs, quality of life, and well-being of the clients receiving services. These therapeutic services were to address topics such as anger management, coping skills, grief and loss, Sociology, Alcoholic/Narcotics anonymous (AA/NA) treatment, and community socialization skills. A Psychiatric APRN was to come to the facility once a week. A therapist/counselor was to come to the facility at least two times per week and as needed to provide therapeutic mental health services.

However, based on the evidence identified at citation 172NAC19-006.10 the facility failed to arrange and provide therapeutic activities, mental health services, medical needs, or drug and alcohol treatment to meet the care and treatment needs of clients that resided at the facility.

In interviews on 7/12/17 at 3:00pm and 7/13/17 at 2:40pm the Administrator reported the facility provided daily mental treatment during therapeutic group activities. The Administrator stated, the therapeutic groups were conducted by the Administrator and Staff B.

Interview on 7/14/17 at 3:30pm, Staff B reported they conducted therapeutic group activities dealing with mental health and substance abuse issues. However, Staff B stated they did not have a counseling or therapy license.

B. The facility failed to arrange for licensed mental health professionals to provide care and treatment services to meet client needs.

Review of a document provided by the Administrator on 7/11/17 titled "Agreement" (no date) found the facility had a contract with a business titled Family Network that employed a Licensed Mental Health Practitioner (LIMHP) and a Licensed Social Worker (LSW). The contract identified Family Network agreed to provide individual mental health counseling services and one therapeutic group session per week to the individuals residing at the facility. The contract described the individual counseling consisted of one-to-one counseling therapy would be provided as authorized by the client's insurance provider.

Review of the facility's personnel list found no evidence the facility employed another licensed mental health care professionals who had within their scope of practice to provide therapeutic mental health care and treatment.

In an interview on 7/13/17 at 2:40pm the Administrator reported the facility had contracts with Family Network to provide one-to-one counseling and therapeutic groups by the LIMHP.

In an interview on 7/10/17 at 5:27pm the Licensed Practical Nurse (LPN) reported the psychiatric APRN conducted evaluations of client's psychotropic medications (about ten to twelve client reviews) via weekly tele-health conferences. The LPN reported Mid-Plains Center for Behavioral Healthcare Services, Inc. provided no other therapeutic services for the facility. The LPN stated the LIMHP provided client individual therapy, reviewed Individual Service Plans (ISPs), and provided no other services.

In an interview on 7/21/17 at 11:59am, the LSW reported the contract was not viable as the LSW terminated the contract (in a letter to the Administrator) in May 2016 or June 2016. The LSW stated they did not currently and had not provided therapeutic groups, counseling services, and/or other mental health services to the facility for over one year.

In an interview on 7/12/17 at 12:40pm, the LIMHP stated they did not directly work for the facility. The LIMHP stated their primary role was to provide one-to-one individual counseling therapy to the clients as approved by insurance. The LIMHP stated they were onsite one day per week, usually on Wednesday, to provide 1:1 counseling therapy. The LIMHP reported they participated in development and reviewed client individual service plans (ISPs), however, the LIMHP did not conduct therapeutic groups, staff training, and/or develop policies for the facility.

C. Failure to develop a plan for the provision of emergency treatment, provide qualified staff to prevent and/or intervene with client mental health emergencies, and ensure clients who posed an imminent danger to themselves or others had access to emergency psychiatric treatment 24-hours a day, 7 days a week.

Review of the facility's Program Description dated 4/1/13 found staff were to be properly educated and trained how to handle and de-escalate psychiatric, behavioral, and medical emergencies to ensure safety of the clients. However, if the techniques failed to solve the immediate problem and a threat of danger to self and/or others existed 911 would be called.

Review of the policy titled "Emergency Services for Mental Health Life Quest" dated 2/12/12 found the policy identified staff would be trained in behavior intervention techniques which included de-escalation, protective measures, and injury prevention. If a client did not de-escalate their behaviors, destroyed property, or harmed other clients, themselves, or staff the facility would call 911 for emergency protective custody (EPC) and transfer the client to the acute psychiatric unit at Mary Lanning hospital. The LMHP and a Psychiatrist were to be notified within 24-hours of the behavioral or psychiatric incident. However, this policy failed to identify who the LMHP and Psychiatrist were and how the facility would ensure emergency treatment was available to clients if there were no available acute hospital beds or the client did not meet the EPC parameters.

Review of the facility's contracts and agreements provided on 7/11/17 by the Administrator found no evidence the facility had an agreement with Mary Lanning hospital, another psychiatric acute care facility, or licensed mental health care professionals to provide the facility with 24-hour 7-day a week emergency psychiatric care and treatment support.

Review of the policy titled "Criteria for On Call Staffing" dated 1/20/14 found on-call staff were to report onsite when called, to ensure client and staff safety in incidents when a client's behavior escalated, redirection failed, refusal of PRN psychotropic medication, or behaviors which led to harm and/or suicidal ideations.

Interview on 7/12/17 at 3:35pm Staff A reported if a client was upset or showing signs of aggression Staff A would talk calmly and redirect the client from the area/activity. Staff A stated the Administrator/RN trained Staff A in crisis intervention, de-escalation, and to call law enforcement when clients were physically aggressive.

Interview on 7/14/17 at 3:30pm, Staff B reported they were trained to de-escalate clients that were upset and to call 911 for support. Staff B stated if two taller male clients argued and became physically aggressive given the circumstances, Staff B would not risk injuring themselves and would call 911.

Review of the following facility incident reports and law enforcement records found the facility failed to develop or implement a plan and ensure emergency mental health services were met for clients who posed a danger to themselves or others:

- a. Review of the document titled "Behavior Incident Report" dated 1/15/16 at 8:30pm found Client 10 talked on the phone to their girlfriend then became upset and angry. Client 10 went to the medication room, yelled at Staff I stating Client 10 needed to go to the hospital. Client 10 then went to their bedroom and returned to the medication room brandishing a pocketknife threatening to cut themselves, stab other clients, and elope. Staff I remained in the medication

room, called the Administrator/RN and reported Client 10's behaviors. The Administrator/RN attempted to talk to Client 10 on the phone, however Client 10 hung up and walked outside. The Administrator/RN instructed Staff I to call law enforcement and have Client 10 removed from the facility. Client 10 later surrendered the pocket knife to Staff I. The Administrator/RN noted on 1/18/17 Client 10 was admitted to Richard Young hospital for treatment.

Review of a law enforcement report dated 1/15/16 at 9:05pm found Client 10 threatened to harm Staff I and to kill themselves with a pocket knife. Staff I locked themselves in the medication room, contacted law enforcement, and watched Client 10 on the video monitors pacing the hallways and dining room with the pocket-knife while other clients were present. After eleven minutes, Staff I reported to dispatch they had left the medication room and talked Client 10 into surrendering the pocket knife. Client 10 reported to law enforcement they were depressed, wanted to kill themselves, and wanted to leave/move away from the facility. Law enforcement placed Client 10 in emergency protective custody (EPC), transported Client 10 to the local jail, and later transported Client 10 to a hospital.

Review of these reports found the facility failed to ensure qualified staff were available to handle Client 10's behaviors, as Staff I was the only staff on-duty and locked themselves in the medication room providing no oversight or protection to the other clients.

- b. Review of the documents titled "Incident/Accident Report" and "Behavior Incident Report" dated 1/19/17 at 7:30pm found Client 10 came to the medication room yelled at staff and stated Client 10 was "pissed off" because Client 31 owed other clients money. Staff M asked Client 10 to calm down, then offered Client 10 a PRN Seroquel which Client 10 refused and left the area still angry. When Client 31 came to the medication room to get their medications, Client 10 ran down the hallway yelled at and punched Client 31 in the face. Staff M broke up the fight, separated the clients, sent Client 10 to their bedroom, had client 31 wait in the chart room to tend to wounds, called the Administrator, and law enforcement. At 8:15pm the facility took Client 31 to a local hospital where Client 31 received two stitches on their lip and returned to the facility.

Review of a law enforcement report dated 1/19/17 at 7:31pm found Staff M contacted law enforcement requesting onsite assistance as Client 10 had punched Client 31. Client 31 received a laceration to their lip and had a tooth knocked out. Staff M reported to law enforcement that prior to the incident Client 10 stated they were angry with Client 31 as Client 31 owed Client 10's roommate money. Client 10 admitted to law enforcement they had punched Client 31 twice in the face. Law enforcement finished their investigation and charged Client 10 with criminal mischief and third degree assault.

Review of these reports found the facility failed to ensure sufficient and qualified staff were available to handle and de-escalate Client 10's aggressive behaviors and to protect Client 31. The facility report provided no evidence how the facility supported Client 31 regarding the incident to ensure safety. In addition, review of Client 10's record found no evidence what mental health supports the facility provided Client 10.

- c. Review of the documents titled "Incident/Accident Report" and "Behavior Incident Report" dated 1/20/17 at 5:55pm found Client 55 came to the chart room, threw a cut up pop can at staff, and showed cuts on Client 55's forearms. The Administrator/RN was notified of the



incident and directed Staff A to call Mary Lanning and Richard Young psychiatric hospitals, however there were no available treatment beds. While waiting in the chart room Client 55 attempted to grab a glass candle to cut themselves, staff tried to stop Client 55, and Client 55 attacked staff. Staff A called 911, law enforcement arrived at 6:20pm.

Review of a law enforcement report dated 1/20/17 at 5:58pm found Staff A contacted law enforcement reporting Client 55 assaulted a staff member. Client 55 was hearing voices so the facility contacted two psychiatric hospitals that would not admit Client 55. With law enforcement onsite, Client 55 began to calm down. Law enforcement identified Client 55 sustained two lacerations to their forearm and contacted the local rescue department to come onsite to attend to Client 55 and another client.

Review of Client 55's Discharge Summary identified Client 55 was discharged on 1/20/17 because "Life Quest not being able to fulfill his needs."

Review of the above reports found the facility failed to ensure qualified staff were available to provide emergency care and treatment to handle Client 55's self-abuse, aggressive behaviors, and medical treatment besides notification to law enforcement.

- d. Review of the document titled "Behavior Incident Report" dated 1/20/17 at 4:50pm identified Client 54 was upset at supertime and wanted to go to the hospital. The report identified Client 54 liked being hospitalized. Staff called the Administrator/RN and then offered Client 54 a PRN which Client 54 refused. Client 54 paced the central hallway and dining room, yelled at others, hit and broke wall hangings, and threw condiment containers and cups on the floor. Law enforcement was onsite for another client, intervened and tried to talk to Client 54 however Client 54 refused to listen and continued their behaviors. Law enforcement hand cuffed Client 54 and issued a citation.

Review of a law enforcement report dated 1/21/17 at approximately 5:59pm found law enforcement officers were onsite 1/20/17 for another incident, however found Client 54 in the dining room throwing cups, trays, and condiments destroying property and yelling loudly. Law enforcement engaged and attempted to de-escalate Client 54 to which Client 54 replied they wanted to go to the hospital for mental health treatment. When law enforcement advised Client 54 that was the reason Client 54 was at the facility, Client 54 continue to yell at other residents. Law enforcement escorted Client 54 to their bedroom, however Client 54 verbally aggressed and threatened to destroy their roommate's personal items. Client 54 returned to the dining room throwing and breaking condiment containers, cups, and trays on the floor. Law enforcement detained Client 54 on the ground then escorted Client 54 out of the facility. Client 54 continued to yell at staff, other clients, and law enforcement. Client 54 kicked two law enforcement officers, resulting in a citations issued for disturbing the peace, criminal mischief, and two counts of assault to a peace officer. Client 54 did not meet the criteria for EPC and was released back to the facility.

Review of the above report found the facility failed to identify what emergency mental health supports and safeguards the facility implemented to protect Client 54 and others from Client 54's aggressive behaviors.

***19-006.03 Staff Requirements: The facility must maintain a sufficient number of staff with the required training and skills necessary to meet the clients' needs. The facility must provide care and treatment to clients in a safe and timely manner.***

***19-006.03A Facility Staffing: the facility must at all times maintain enough staff to provide adequate care to meet the client population's requirements for care and treatment, including needs for therapeutic activities, supervision, support, health and safety.***

Findings:

Interviews and record reviews identified the facility failed to ensure a sufficient number of staff were on duty on all shifts to provide necessary supervision and to meet the care, treatment, and safety needs of all clients. In addition, the facility relied on clients and non-employees to perform duties of a staff person. This affected all clients that resided at the facility.

The facility program description specified the facility provided 24 hour a day, awake staff to ensure the safety and well-being of each client. All clients were monitored on an ongoing basis to determine the level of care and to ensure that client's needs are being met.

The facility is licensed for 55 beds in two separate un-joined buildings. The main building has 41 beds/clients and the building called the "Annex" has 14 beds/clients. Staff for each shift are located in the main building with no staff located in the Annex.

Review of the Direct Support/Medication Aide Job Description, (undated) found the duties were to include but not be limited to: be a registered medication aide; pass medications; assist clients as needed to ensure safety; prep, serve and clean up at meal times; charting on clients, help maintain cleanliness and safety of facility, interact with clients-1:1 time as needed; random checks of facility to ensure all clients are accounted for; be able to perform First Aid and CPR; accompany clients on facility activities, provide transportation and file client documentation.

Observation on 7/10/2017 at 1:22pm found Staff A was assisting Client 3, answering questions from Clients 34, Client 27 and Client 9 and taking phone calls concerning the return of Client 14 to the facility. At 1:35pm when there were no phone calls and no clients to assist, Staff A stated, they were "in charge right here, for right now" as Staff A was the only staff on duty at the facility and Staff B was transporting clients. Staff A reported the census was currently 52, with one client in the hospital, Client 14, and one on a home visit, Client 38.

Review of the staff schedule for 7/10/2017 found the Administrator, Staff D, Staff E, Staff F, Staff G, and Staff H, were all scheduled to be on duty from 8am-4pm.

Interview with Staff A at 3:35pm on 7/12/2017 reported Staff A had worked at the facility for nine years. Staff A stated their job duties, included, "everything", passing medications, answering the phone, checking on clients. Staff A stated when there was a second staff on duty, then they also served meals, did dishes and cooked. However, Staff A stated, when there is no other staff, usually on Saturday's and Sunday's, Staff A cooks both lunch and supper meals as well as their regular staff duties. Staff A stated there was sufficient staff to pass medications and do some client cares, however Staff A stated there were not enough staff to do everything that needed to be done every day. In addition, Staff A stated, there is never a staff at the Annex, except when doing night rounds.

Interview with Staff C at 9:44am on 7/14/2017 stated staff are busy no matter what shift. Staff C stated the 7a-7p Medication Aide is required to do 7:00am meds, complete all the paperwork for transportation and appointments for the day, answer the phone, check on clients, and med passes at 10:00am, 11:00am, 12:00pm, 2:00pm, 3:00pm and 5:00pm. In addition, Staff C stated the 7a-7p Medication Aide staff were required to keep all charting and medication documentation up to date and fill out any required forms for behavior or accident reporting. Staff C reported the 7p-7a, Medication Aide was required to do overnight checks on the hour. Staff C stated it took about ½ hour to do the nightly hourly check of every room in both buildings. Checks were done from 10:00pm to 6:00am which was considered sleep hours, although curfew was at 10:30pm. In addition, Staff C stated there were also general housekeeping chores to be completed by the overnight staff.

Interview with Staff B on 6/8/2017 at 10:47am and at 3:30pm on 7/14/2017, reported there were enough staff to provide basic needs to clients on most days. However there were days when Staff B reported they should have been cloned 7x to keep up with the demand. Staff B reported that in addition to their 7a-7p regular Medication Aide staff duties, Staff B was also responsible for groups, activities and sometimes transportation of clients. Furthermore Staff B reported there was an issue with drug use by clients on campus, however it was impossible to catch clients when there was only one staff on duty.

The following are examples of the facility's failure to ensure sufficient staff were available to provide necessary supervision to meet the clients' needs.

1. Failure to ensure clients received care and treatment as evidenced throughout this inspection report.
2. Review of Client 61's record found Client 61 was on campus for less than 24 hours and eloped without staff knowledge. The elopement was first identified by a community member who called the facility.
3. Observation on 6/9/2017 at 9:35am found Client 13 was walking west on Commercial St, the street that runs in front of the facility. Client 13 was about 3 blocks from the facility. Upon entering the facility, the survey team asked the staff on duty, Staff A if Client 13 was to be walking alone, away from the building towards the edge of town. Staff A stated they had no idea that Client 13 had left the campus.
4. Review of Behavioral Incident Report dated 3/20/2016 identified staff could not locate Client 12 on campus at 8:00pm. A missing person report was filed with Law Enforcement. Client 12 returned to the facility at 10:30am on 3/21/2017.
5. Review of Nurses Note, entry for Client 10, dated 6/8/2017; Staff A reported an incident at 7:05pm between Client 10 and Client 18. Staff A reported, Client 10 threatened physical aggression to Client 18. Staff A, stepped between the two clients and attempted to de-escalate the situation.

Interview with Staff A on 6/9/2017 stated they intervened only at the threat of physical harm by Client 10 as Staff A was to be off duty at 7:00pm. However, Staff A stayed to deal with the incident because the staff on duty, Staff I was unable to handle the situation.

6. Review of Behavioral Incident report dated 1/15/2016 reported Client 10 showed Staff I, a pocket knife. Client 10 threatened to cut themselves, and stab other clients. Staff I locked themselves in the medication room, notified the Administrator/RN who instructed Staff I to call 911. When Law Enforcement arrived, de-escalated Client 10 and placed Client 10 into emergency protective custody.

Review of a Law enforcement report dated 1/15/16 at 9:05pm identified Client 10 used a pocket knife to threaten harm themselves, other clients, and Staff I. This report identified Staff I had locked themselves in the medication room until law enforcement arrived.

Client I left the rest of the clients unattended and without staff as there was no other staff on duty at the time.

7. Review of Nurses Note entry for Client 9, dated 6/3/2017 staff reported Law Enforcement was called by clients to talk to Client 9 for yelling. There was no further information provided as to why Law Enforcement would have been called for a yelling client.

8. Clients performing duties that the facility has responsibility.

Interview with Staff B on 6/8/2017 at 10:47am stated there was no housekeeper at this time so cleaning was the staff's responsibility.

Interview with Staff G, the facility cook, on 6/8/2017 at 10:10am stated they did most of the cooking, except breakfast and on the weekends. Staff G reported staff take care of breakfast and clients help clean up.

Interview with Staff A on 7/12/2017 at 3:35pm stated usually the clients cleaned the facility and cooked breakfast on the weekends.

Observation on 7/10/17 at 1:26pm found Client 10 in the Dishwasher room spraying off dishes, operating the dishwasher, drying, and putting dishes away.

Observation on 6/6/2017 at 8:14am found an unidentified client with mop and bucket mopping the hallways. Interview with Staff C, the staff on duty at the time of the observation, reported the client was Client 24.

Observation on 7/13/2017 at 10:15am found Client 24 cleaning the hallways and public bathrooms.

Interview with Client 24 on 6/8/2017 at 9:04am reported they were in charge of cleaning the public bathrooms and the 2 hallways. Client 24 reported they also clean the kitchen. Client 24 reported they regularly cook breakfast, and Client 16 cooks as well.

Interview on 7/13/17 at 2:20pm with Client 45 reported they "volunteered" to do facility and Client 9, Client 23, Client 35, and Client 52's personal laundry because these clients were "crippled up and not in good shape."

9. Interview/observation with the LPN on 7/10/2017 at 2:30pm found Client 14 had fallen on 7/2/2017, and again on 7/5/2017 and as a result was taken to the hospital emergency room (ER).

Observation at 5:20pm on 7/10/2017, Client 14 returned to the facility and with 1-1 assistance Client 14 walked to the dining room. At 6:13pm the LPN gave specific instructions to Staff A and Staff B that Client 14 should not be left alone and should not be walking. The LPN contacted the Administrator/RN regarding the need for Client 14 to have additional assistance during the night, however the RN stated as the overnight staff was also a CNA, and the staffing could remain the same. At 6:35pm the LPN was no longer in the dining room, Staff B was in the medication room and Staff A was assisting Client 30 with

a leg wrap in the dining room. Client 14 got up from the table took their tray to the dishwashing room and started to leave the dining room without staff knowledge or assistance.

The LPN reported on 7/11/2017 at 10:00am the LPN stayed with Client 14 until 10:30pm, however there was only one overnight staff on duty until from 10:30pm to 7:00am to assist Client 14 and all the other clients at the facility.

Observation/interview on 7/11/2017 at 8:07am in the dining room found Client 14 unassisted by staff arrived at the dining room for breakfast. Client 52, Client 14's roommate reported Client 14 had fallen in their bedroom that morning as no staff came to assist Client 14 in getting up and ready for the day.

10. Interview with Staff A on 7/10/2017 at 1:45pm reported Client 30 had cellulitis in their leg.

Observation at 6:25pm, on 7/10/2017, found Client 30 in the dining room, had reported to Staff A Client 30's leg was numb and sore. Staff A, checked Client 30's leg, the leg was found to be reddish almost purple in color and had open sores on both the front and the back of the leg. While Client 30 remained seated in the dining room, Staff A re-wrapped Client 30's leg. Staff A stated they would have gone to the med room to do the wrap but needed to watch Client 14 finish supper as directed by the LPN and there were no other staff available.

11. Review of facility investigation dated 7/17/17 found Client 19 reported having sex with Client 47 in Client 19's bedroom on two different occasions which was Skyped for others to see. Client 19 reported they had waited for staff rounds to be completed, got Client 47, Skyped Client 19's contacts and had sex. Client 47 confirmed having sex with Client 19 which was skyped.

12. In an interview on 7/10/17 at 4:20pm Client 2, found Client 2 showed their breasts to Client 33 (a male client) to earn a pop. Client 2 stated Client 33 asked most of the females residing at the facility to come to Client 33's bedroom and show Client 33 their breasts in exchange for pop or \$1.00.

In an interview on 7/11/17 at 10:45am, Client 33 reported they had given pop and money to female clients residing at the facility for showing their breasts and to "give me blowjobs." Client 33 stated these acts took place in Client 33's bedroom. Client 33 reported they had a criminal history of sexual abuse and had spent time in jail. Review of the Nebraska Sex Offender Registry found Client 33 was registered as a Lifetime Offender.

**19-006.03D The facility must provide staff with sufficient training to meet client needs for care and treatment of clients.**

**19-006.03D1 Initial Orientation The facility must provide staff with orientation prior to the staff person having direct responsibility for care and treatment of clients. The training must include:**

- 1. Client Rights;**
- 2. Job responsibilities relating to care and treatment programs and client interactions;**
- 3. Emergency procedures including information regarding availability and notification;**
- 4. Information on any physical and mental special needs of the clients of the facility; and**
- 5. Information on abuse, neglect, and misappropriation of money or property of a client and the reporting procedures.**

***19-006.03D2 Ongoing Training The facility must provide each staff person ongoing training in topics appropriate to the staff person's job duties, including meeting the needs, preferences, and protecting the rights of the clients in the facility.***

This standard is not met as evidenced by:

Based on record review and interview the facility failed to ensure all staff had the necessary training to be able to meet the needs of clients served in the facility and provide assistance as needed which had the potential to affect all 52 clients in the facility.

Findings:

Review of the Resident Assistant/Medication Aide Job Description, (undated) identified staff must be responsible to oversee the resident's care needs and provide assistance as needed.

The facility program description specified the facility provided 24 hour a day, awake staff to ensure the safety and well-being of each client. All clients were monitored on an ongoing basis to ensure client needs were being met.

The following are examples of incidents where there was evidence of lack of staff training:

An interview with Staff A at 10:10am on 6/9/2017 reported Staff I was unable to handle a physical aggression incident between Client 18 and Client 10 the evening of 6/8/17 and as a result Staff A stayed beyond the end of the shift to ensure client safety.

Review of a 11/15/16 Behavioral Incident report identified Client 10 threatened and hit Client 31 in the head and face. Client 31 received injuries to their upper lip. The Behavioral Incident Report failed to identify what staff had done to intervene and protect clients. Staff I assessed Client 31's injuries and took Client 31 to the Emergency room for stitches.

An interview with Staff B on 7/14/17 at 3:30pm found Staff B had reported if there were two big guys beating on each other, Staff B would be calling law enforcement because Staff B stated they would not risk themselves. Staff B added that it depends on the circumstances how much you do as a staff. Staff B reported training they received was primarily in de-escalation techniques and that law enforcement was only to be called as a last resort.

Interview with Staff A on 7/12/17 at 11:00am reported not knowing that they were to assist the clients with helping them or assisting them with cleaning their room. Staff A's hire date was 12/10/08, 9 years as a staff.

Interview with Staff B on 7/14/17 at 3:31pm reported they receive ongoing training once a month in CPR, First Aide, Crisis Intervention and how to handle behaviors.

***19-006.13 Client Assessment Requirements: The facility must complete the following assessments prior to the development of the individualized service plan:***

***1. Assessments of current functioning according to presenting problem including community living skills, independent living skills and emotional psychological health;***

**2. Basic medical history and information, determination of the necessity of a medical examination or the results of the medical examination.**

**3. Current prescribed medications and, if available, history of medications used; and**

**4. Summary of prior mental health treatment and, if available, service system involvement.**

This standard is not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete current client need assessments for 10 of 10 sampled clients. (Client 1, Client 2, Client 3, Client 4, Client 5, Client 6, Client 7, Client 8, Client 9 and Client 10).

Findings:

Interview with the Administrator/Registered Nurse (RN) on 7/13/2017 at 1:00pm, reported the facility completed a new client assessment within 30-days of admission. The Administrator/RN identified the facility's assessment packet included a nursing assessment, a self-administration of medications, the Functional Assessment, and the Life Quest Mental Health Assessment.

#### Client 1

Review of the document titled, "Client Face Sheet" identified Client 1 was admitted on 7/10/12 and had the following diagnosis: Chronic Pain, Major Depression, Anxiety and Paranoid Schizophrenia.

Review of Practitioner's Appointment Sheet dated 11/7/2014 identified Client 1 had been diagnosed with Chronic Pain, Constipation, Depression, Anxiety, hypothyroidism, Cerebral Embolism, Aerial Fibrillation and Paranoid Schizophrenia.

Review of Client 1's record found no evidence which identified where these diagnosis came from and documentation of an assessment by a licensed health care practitioner.

#### Client 2

Review of the document titled "Client Face Sheet" found Client 2 was admitted on 9/14/15 and had the following diagnosis: Schizo-affective disorder Bi-polar type, PTSD, Borderline personality disorder, protein deficiency, and seizures.

Review of Client 2's record found a document titled "Region 6 Recovery Center Client Progress Notes" (dated 8/27/15) identified Client 2's diagnosis' were Depression, Schizoaffective disorder (auditory hallucinations), post-traumatic stress disorder (PTSD), suicidal ideations, and elopements.

Review of records found no evidence that prior to development of the Individual Service Plan (ISP) the facility ensured Client 2 received an assessment by a Licensed Health Care Professional who had within their scope of practice the authority to assess emotional and psychological health.

Review of Client 2's record found the facility had information of Client 2's suicidal ideations and elopement risks, however failed to assess Client 2 for these needs.

Review of Client 2's record found a document from a hospital that identified Client 2 was admitted to the acute inpatient psychiatric unit on 9/28/15 (2 weeks after admission to the facility) for self-harming and a suicidal attempt. However, the facility failed to complete assessments on suicide or elopement risk until 10/16/2015, as recorded on documents, "Suicide/Self-Harm and Elopement Risk Assessment" dated 10/16/15 and the "Elopement Risk Assessment" dated 10/23/15. Neither document was completed until after Client 2's hospitalization on 9/28/2015.

### Client 3

Review of the document titled "Client Face Sheet" found Client 3 was admitted to the facility on 6/6/17 with a diagnosis of Huntington's disease, Depression, Mood disorder, and Hypertension.

Review of the healthcare summary documents from a hospital (dated 5/28/17) and Patient Discharge Instructions (dated 6/6/17) found Client 3 was diagnosed with Psychotic disorder, Personality Disorder secondary to Huntington Disease, Huntington's disease, suicidal and homicidal ideations, Depression, and Hypertension.

Review of Client 3's record on 7/14/17 found Client 3 did not have an Individual Service Plan in place.

Review of Client 3's records found no evidence at the time of admission Client 3 received an assessment by a Licensed Health Care Professional who had within their scope of practice the authority to assess and diagnose emotional and psychological health.

In an interview on 7/10/17 at 5:27pm the LPN confirmed there was no assessment.

### Client 4

Client 4 was admitted on 11/12/03.

Review of the document titled, "Client Face Sheet" found Client 4 was admitted on 11/12/03 and identified the following diagnosis: Schizoaffective Disorder – Bi Polar Type; Personality Disorder NOS with Paranoid Traits.

Review of Client 4's assessment document titled "Life Quest at the Coolidge Center Admission Assessment" dated 11/30/2003 identified Client 4's diagnosis as: Bi Polar, Schizoaffective, anxiety disorder and paranoid type personality. This document identified the reason for admission was Client 4's inability to live independently.

Review of Client 4's record found no evidence which identified where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner.

### Client 5

1. Client 5 was admitted on 7/29/16.

Review of the "Client Face Sheet" found Client 5 was admitted on 7/29/16. The diagnosis for Client 5 were found in Client 5's record such as "Client Face Sheet", Resident Admission and Discharge Record; the Nursing Data Information; the Mental Health Questionnaire; Practitioner's Appointment Sheets; Individual Service Plan and the 2/21/2017 Discharge Plan. The diagnosis included: Developmental



Mental Disorder, Psychosis (unspecified type), Bilateral Cataracts, Arthritis, Alcohol Abuse, Asthma, Emphysema, and Chronic Obstructive Pulmonary Disease (COPD).

However there was no evidence in Client 5's records where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner to diagnose and identify medical and mental health needs.

#### Client 6

Review of the "Client Face Sheet" for Client 6 identified Client 6 was admitted on 4/14/14 and identified the following diagnosis: Schizoaffective Disorder, Dementia, Alcohol Dependence and COPD.

However there was no evidence in Client 6's records where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner to diagnose and identify medical and mental health needs.

#### Client 7

Review of the "Client Face sheet and Resident Admission and Discharge Record, found Client 7 was admitted to the facility on 1/30/2009 and identified the following diagnosis: Schizoaffective D/O, Vitamin D deficiency, COPD and Diabetes.

However there was no evidence in Client 7's records where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner to diagnose and identify medical and mental health needs.

#### Client 8

Review of the document titled "Client Face Sheet" (undated) found Client 8 was admitted to the facility on 11/10/09 and identified the following diagnosis: Schizophrenia, reported Hepatitis C, seizure disorder, and COPD.

However there was no evidence in Client 8's records where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner to diagnose and identify medical and mental health needs.

In addition there was no documentation for the reason for admission.

#### Client 9

Review of the document titled, "Client Face Sheet" for Client 9 found Client 9 was admitted to the facility on 1/14/2009 and had the following diagnosis: Bi Polar and Schizoaffective Disorder.

Review of the document titled "Life Quest at the Coolidge Center Admission Assessment" dated 2/5/2009 found the page of the assessment which was used to assess Client 9's mental status assessment was blank. This document identified Client 9 received psychiatric therapy in 1969 for mental health issues and identified Client 9's addictions which included substance abuse and smoking.

Review of Client 9's record found no evidence which identified where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner to diagnose and identify medical and mental health needs.

Client 10

Review of the document titled "Client Face Sheet" (undated) identified Client 10 was admitted to the facility on 4/30/08 and identified diagnosis which included Drug and Alcohol abuse and Gastroesophageal reflux disease (GERD).

Review of the document titled, "Mid-Plains Center Administrative Information," dated 4/27/17 found Client 10's diagnosis to be: Schizophrenia, Attention Deficit/Hyperactivity disorder, and mild mental retardation.

However there was no evidence in Client 10's records where these diagnosis came from and no documentation of an assessment by a licensed health care practitioner to diagnose and identify medical and mental health needs.

***19-006.14 Within 30 days of admission, the facility must develop for each client a written plan, which is based on admission assessment and ongoing assessment information.***

This standard is not met as evidenced by:

Based on record review and interview the facility failed to implement 1 of 1 client's Individual Service Plan (ISP) written within 30 days of admission (Client 3) for one new admission reviewed.

Findings:

Review of the facility's policies titled "Individual Service Plan" (no date) and "Client Admission Policy" (no date) found each client's ISP would be written within 30-days of admission to the facility.

During an interview on 7/13/17 at 2:40pm the Administrator reported within 30-days of admission clients are assessed then an ISP developed. The Administrator stated clients residing at the facility for more than 30-days had current assessments and an ISP.

Review of Client 3's record on 7/14/17 found Client 3 had been admitted to the facility on 6/6/17 for a total of 39 days. However, Client 3's record contained no evidence the facility had developed or implemented an ISP for Client 3.

***19-006.14A The individual service plan must be in writing and include the following items:***

- 1. Client's name***
- 2. Date plan developed***
- 3. Specified client care and treatment needs to be addressed including therapeutic activities, behavioral concerns, self-care, physical and medical needs, and medication regimen.***
- 4. Client goals related to specified needs identified that are to be addressed.***
- 5. Interventions addressing the plan goals and who will be responsible for ensuring interventions are carried out as planned.***

- 6. Documentation of client participation in the planning process.**
- 7. Planned frequency and identification of contacts.**
- 8. Documentation of collaboration with the primary mental health professional in development of the plan.**

This standard is not met as evidenced by:

Based on record review and interview the facility failed to develop individualized service plans (ISPs) to meet each individual's need for care and treatment for 10 of 10 clients reviewed. (Client 1, Client 2, Client 4, Client 5, Client 6, Client 7, Client 8, Client 9, Client 10)

Findings:

Review of the policy "Individual Service Plan" (undated) identified ISPs will be based on the needs of the client identified on the admission assessment, past history, client information, guardian/family input and other identified problem areas. The ISP will contain realistic and measurable goals to build self-esteem, gain independence, control behaviors or prevent regression of their mental illness.

#### Client 1

Review of Client 1's Individual Service Plan (ISP) dated 1/18/17 identified a diagnosis of depression, anxiety and paranoid schizophrenia. Records also identified needs of Client 1's resistance to care and treatment, isolative behavior, refuses showers and baths, room to be cleaned, poor hygiene and grooming.

Client 1's ISP failed to address Client 1's identified needs as the ISP contained one goal which was related to hoarding. Interventions for this goal identified staff were to ask Client 1 if they may remove the hoarded items, getting only a few items at a time. Observation on 7/12/17 at 3:30pm found four food trays in Client 1's room with decaying food.

#### Client 2

Review of Client 2's ISP dated 3/21/17 found Client 2 had diagnosis of schizoaffective disorder, Bi-Polar type, PTSD, Borderline Personality Disorder, Major Depression, and Protein Deficiency. The ISP further identified Client 2 had history of seizures, non-compliance with medications, lacked social skills, poor peer relationships, hypersexual, methamphetamine use, suicidal attempts, and self-injurious behaviors.

Client 2's ISP failed to address Client 2's identified needs as Client 2's 3/21/17 ISP identified Client 2 had one goal to learn "to self-soothe in healthy and appropriate ways as evidenced by not engaging in self-mutilation or suicidal gestures/ideations 100% of the time." Review found the 3/21/17 ISP had the same goal and interventions as the ISP's dated 9/22/16 and 3/28/16 (with the exception of the name of psychiatric APRN).

Review found the interventions to the goal to be vague and identified "staff" were the responsible party to ensure Client 2's interventions were carried out at a "prn" frequency. Interventions identified staff were to offer coping skills when Client 2 engaged in self-harm or suicidal ideations and to encourage Client 2 to participate in day program and community activities. These interventions failed to identify proactive treatment methods to teach Client 2 how to manage their feelings, mental health, and daily routine as the interventions were reactive to Client 2's behaviors or refusal to participate.

During interviews on 7/10/17 at 3:55pm and 7/11/17 at 8:25am, Client 2 stated they suffered from suicidal thoughts, anxiety issues, and needed assistance with independent skills like budgeting, cooking, and medications. Client 2 reported they did not want to live at the facility as the facility did not meet their mental health needs or personal goals to have skills to live in the community. On 7/10/17 Client 2 provided a document which Client 2 reported they developed to track their own treatment goals not reflected on their ISP. The document (note book paper with columns identifying tasks and rows with days of the week and initials) identified Client 2's daily goals/tasks were to take pills, clean room, no self-harm, shower, and attend appointments. Client 2 reported they had staff initial/sign-off daily for each item Client 2 completed.

#### Client 3

Review of Client 3's record on 7/14/17 found Client 3 did not have an Individual Service Plan in place. Client 3 had been admitted to the facility on 6/6/17, however there was no evidence the facility had developed or implemented an ISP for Client 3.

#### Client 4

Review of Client 4's ISP dated 5/22/17 identified Client 4's diagnosis as mental illness and indicated Client 4 has never believed they were mentally ill which has been Client 4's biggest challenge. Client 4's history includes: physical and emotional abuse by parents; obsessive behaviors, demanding behaviors, false allegations, fabricates to make self a victim, changes religions to get a rise in people, poor judgment, poor impulse control, and resistive to medications and treatment. Client 4 receives an IM injection monthly by a licensed nurse. Special needs: false allegations, false reporting, anxiety, intrusiveness and elopement risk.

Client 4's ISP dated 5/23/17 failed to address Client 4's identified care and treatment needs as the ISP contained one goal for Client 4 which was to increase insight of their mental illness by learning one of their medications monthly. Four of the eight interventions identified staff or the nurse will print out the information on one of Client 4's medications monthly. Staff will have Client 4 review the information monthly. The last week of the month the nurse will quiz Client 4. Staff were to provide Client 4 information about one of Client 4's medications at the beginning of the month. It is then up to Client 4 to take it upon them self to review the information throughout the month to be able to pass the quiz given by the LPN at the end of the month.

#### Client 5

Review of Client 5's ISP dated 2/21/17 found Client 5 was admitted on 7/29/16. The ISP cover page identified the following: Client 5's history identified Client 5 had anger issues at a previous living situation; diagnosis of Developmental Mental Disorder, Psychosis (unspecified type), Bilateral Cataracts, Arthritis, Alcohol Abuse, Asthma, Emphysema and COPD; Client self-care- needed assistance with medication, hygiene reminders, monitoring of cell phone usage and monitoring tobacco usage.

Client 5's ISP dated 2/21/17 failed to address Client 5's identified care and treatment needs as the ISP contained one goal which was for Client 5 to follow their daily routine which included daily responsibilities and socialization. The goal identified Client 5 was to participate in Client 5's daily routine with less than five reminders per day.

The goal included eight interventions to assist Client 5 in meeting the goal, which included three different staff reminders to Client 5 on the daily schedule: 1) staff documenting Client 5's success or

failure to follow the daily schedule, 2) praising Client 5 for following the daily schedule, 3) the APRN will monitor Client 5's medications and psychiatric needs. However Client 5 no longer takes medications for psychiatric needs.

#### Client 6

Review of Client 6's ISP dated 5/23/17 identified the following care and treatment needs: Client history reported Client 6 had a long history of alcohol dependence, subsequent dementia, Schizo-affective Disorder and COPD; diagnosis of Schizo-affective Disorder, Dementia, Alcohol Dependence, and COPD; history and a current issue with medication non-compliance; self-care needs-needed assistance with forgetfulness, anxiety, intrusive at times, anger outbursts, wheel chair if needed when Client 6 is in pain, and attention seeking.

Client 6's ISP dated 5/23/17 failed to address Client 6's identified care and treatment needs as the ISP contained one goal which was Client 6 would use coping skills when frustrated, in pain, or angry as evidenced by less than two episodes of anger weekly.

The goal included seven interventions to assist Client 6 in meeting the goal, which included two different staff reminders to Client 6 to go to groups and to use Client 6's coping skills. Two on staff documenting Client 6's success or failure in going to groups and using coping skills; one on one staff praising Client 6 for using coping skills, one which identified, the LIMHP would work with Client 6 in developing coping skills monthly and as a prn, and one which identified the APRN will monitor Client 6's medications and side effects and make changes as needed every 2 months or as a prn.

Client 6's coping skills were listed as listening to music, playing the piano, computer, playing music in Client 6's room, smoking, talking with staff, and taking a walk.

Review of Client 6's medical record found Client 6's smoking was a contributing factor to Client 6's reported chest pain. However there was no identification in Client 6's record of providing Client 6 with smoking cessation options.

Review of June 2017 "Behavioral Grid" for Client 6 found the grid broken into Dayshift and Nightshift sections with a box for each day in the month. Client 6's goals for the Dayshift were 1. Attends group daily and 2. Angry outbursts. Client 6 was found to have not attended one group during the Dayshift in June 2017. In addition, the second goal, Anger outbursts, found Client 6 had three angry outbursts in June 2017.

Review of Client 6's June 2017 "Group Participation Record" found Client 6 did not participate in any weekend activities. In addition, the record showed Client 6 was absent/off campus for 4 group/activity offerings. Out of 84 groups and activities offered in June, Client 6's Group Participation Record reported Client 6 participated in only 7 groups/activities. The other 77 group/activity times were recorded as non participated.

Interview with Client 6 on 7/14/17 at 10:30am reported Client 6 usually does not attend the groups or activities provided by the facility as the groups don't really apply to Client 6.

#### Client 7

Review of Client 7's 2/21/17 ISP found Client 7 was admitted on 1/30/09. The ISP identified: Client history of fixed delusions and not being medication compliant was referred by Client 7's psychiatrist as unable to live independently; diagnosis of Schizo-affective Disorder, Diabetes-insulin dependent, COPD

and Vitamin D deficiency; able to do their own blood sugars; and self-care- needed prompts to attend physician appointments and cues for medications.

Client 7's ISP dated 2/21/17 failed to address Client 7's identified care and treatment needs as the ISP contained one goal which was Client 7 would decrease their delusions as evidenced by attending all medical appointments and psychiatric appointments 100% of the time.

The goal included seven interventions to assist Client 7 in meeting the goal, which included three different staff reminders to Client 7 to go to appointments, 1) staff documenting Client 7's success or failure in attending appointments; 2) documenting if Client 7 had delusions as well as documenting if Client 7 attended their appointments prn, and 3) Client 7's psychiatrist would monitor Client 7's medications and side effects and make changes as needed every 3 months and prn.

Client 7's ISP dated 2/21/17 was worded identically to the 8/22/16 ISP.

Review of June 2017 Behavioral Grid for Client 7 found the grid broken into Dayshift and Nightshift sections with a box for each day in the month. Client 7's goals for both the Dayshift and the night shift was Delusions. Per the June 2017 Behavioral Grid, Client 7 had delusions every day for the entire month during the day shift, and there were no delusions documented for the entire month of the night shift. In addition, the Dayshift was also to document attending physician/psychiatric appointments. Per the Grid, Client 7 had 29 days of not applicable-with no other further information provided; and 1 day, June 9, 2017 when Client 7 did attend appointments. However, per Client 7's medical record, Client 7 attended physician appointments on June 9, June 16 and June 20, 2017. The June 9 appointment had to be rescheduled as noted on the paperwork, as Client 9 was unable to stay awake.

#### Client 8

Review of Client 8's "Face Sheet" and 6/27/17 ISP found Client 8 was admitted to the facility on 11/10/09. Diagnosis of Schizophrenia, Hepatitis C, seizure disorder, COPD, paranoia; history of drug abuse, failed independent living situation, non-compliance with medication, social isolation, withdrawn behaviors, elopement, poor money and self-image.

Review of the 6/27/17 ISP found it contained the exact same goals and interventions as identified in Client 8's previous ISP's dated 6/20/16 and 12/20/16 (with the exception of the psychiatric APRN's name).

Client 8's ISP dated 2/21/17 failed to address Client 8's identified care and treatment needs as the ISP contained one goal which was Client 8's would self-advocate for themselves one time weekly for 25% of the time

Review found the ISP goal had seven interventions which were vague and identified "staff" were responsible to ensure Client 8's interventions occurred one-time per week or at a "prn" frequency. Four interventions identified what staff would do to document and offer positive reinforcement to Client 8 when Client 8 advocated for themselves. Two interventions identified Client 8 would be seen by the psychiatric APRN every three months and the counselor "prn".

Review of the document titled Nurse's Notes found since 10/18/16 Client 8 had seen the psychiatric APRN on 12/13/16 and 4/12/17 for medication reviews and had not been to counseling with the Licensed Mental Health Practitioner (LIMHP).

Review of Client 8's ISP data sheets from April 2017 through June 2017 found Client 8 made no progress and did not meet their goal as staff recorded "N" (no) each day and evening for 181 instances. Further review found, the interdisciplinary team made no changes to Client 8's ISP, goal, or interventions between the 6/20/16, 12/20/16, and 6/27/17 ISPs.

Review of Client 8's assessment titled "Life Quest Mental Health Assessment" dated 11/10/09 identified at admission Client 8 took their medications, read/knew of the side effects, and had "always taken their meds." However the 6/27/17 ISP identified Client 8 was now non-compliant with taking medications. Client 8's 6/27/17 ISP provided no information about what changed or caused Client 8's decline in their skills to self-administer their medications.

#### Client 9

Review of Client 9's "Face Sheet" identified Client 9 was admitted on 1/14/09 with a diagnosis of Bi Polar, Schizoaffective Disorder and COPD.

Review of Client 9's ISP dated 2/21/17 identified Client 9 was admitted to the facility with Bi-Polar, Schizoaffective Disorder, delusions and was resistive to medications.

Client 9's ISP dated 2/21/17 failed to address Client 9's identified care and treatment needs as the ISP contained one goal which Client 9's is to gain insight into their mental illness as evidenced by self-reporting to staff when Client 9 has delusional thoughts, hears voice chattering, and/or hallucinations for 100% of the time.

The goal included interventions to assist Client 9, which included attendance at self-help groups, individual therapy monthly, and report to staff issues. Staff will bring Client 9 back to reality and encourage Client 9 to use their coping skills. Staff will report to the nurse and/or doctor what Client 9 has reported to the staff. Staff will give verbal praise to Client 9 for participating in groups daily on the behavioral log. Staff will document on the behavioral log any episodes of delusional thoughts, hearing voices or hallucinations. Review of the interventions identified the APRN will monitor medications for effectiveness, and change as necessary.

Interview with Client 9 on 7/12/17 at 8:52am reported that they enjoy attending groups. Client 9 is supposed to tell staff when they hear voices. Client 9 stated they report to staff when they hear the voices but reported not liking that the medication they give Client 9 makes Client 9 too tired to be able to go to participate in all of the things that Client 9 enjoys.

Review of facility records from April 1, 2017 through July 14, 2017 identified that Client 9 had only participated in 138 out of 288 therapeutic mental health groups and daily care activities.

#### Client 10

Review of Client 10's ISP dated 5/23/17 identified Client 10 was diagnosed with Schizophrenia, mild MR, Hepatitis C, history of drug and alcohol abuse, failed living situations, unresolved grief, and poor hygiene, grooming, relationships, social skills, and impulse control.

Client 10's ISP dated 5/23/17 failed to address Client 10's identified care and treatment needs as the ISP contained one goal which Client 10 would develop coping skills and relaxation techniques to deal with their anger "by one or less episodes of anger outbursts three times per month". The review found the goal was not measurable.

Review of Client 10's ISP dated 5/23/17 found of the six interventions identified, staff would document data collection and provide verbal praise for using coping skills. Of the six interventions, three interventions identified Client 10 would work on coping skills and relation techniques, however the ISP contained no information what those coping skills and relaxation techniques were and what Client 10 was supposed to do. The ISP provided no evidence what staff were to do when Client 8 displayed verbal or physical aggression, refused to participate in group activities and participate in therapy with licensed professionals.

Review of the 5/23/17 ISP identified Client 10 would attend therapeutic groups and activities to learn coping skills and relaxation techniques. Review of Client 10's therapeutic group activity attendance record found Client 10 attended 26 of 288 groups between April 2017 and July 12, 2017.

***19-006.16E Administration of Medication: Each facility must establish and implement policies and procedures to ensure that clients receive medications only as legally prescribed by a medical practitioner in accordance with the five rights and with prevailing professional standards.***

This standard is not met as evidenced by:

Based on record review, observation, and interview the facility failed to ensure medications were provided according physician orders and prevailing professional standards which affected 10 clients. (Client 3, Client 7, Client 12, Client 15, Client 16, Client 24, Client 25, Client 30, Client 39, and Client 42).

Findings:

1. Review of the facility policy titled "Medication Administration Policy" (undated) identified MARs (medication administration records) would be kept current and immediately updated upon notification by the client's physician of adjustments or changes to medications.

#### Client 3

Review of Client 3's document titled "Mary Lanning Health Discharge Instructions" found Client 3 was diagnosed with "Psychotic disorder, Personality disorder secondary to Huntington's disease."

Review of the document titled "Hansen Medical, PC: Visit Note/Transition of Care" dated 7/3/17 found Client 3 was prescribed Tetrabenzine 12.5mg (for their Huntington's disease); discontinued Citalopram 10mg due to negative interactions with the Tetrabenzine; and prescribed Zoloft 50mg in exchange of the Citalopram.

However, review on 7/14/17 of Client 3's July 2017 MAR (provided on 7/12/17) found:

- a) Tetrabenzine was not listed on the MAR as a prescribed medication for 9 days;
- b) Client 3 continued to receive Citalopram 10mg at 8:00am from 7/1/17 through 7/12/17 and Client 3 received Zoloft 50mg at 8:00am from 7/4/17 through 7/12/17, however, as per the physician's order the Zoloft was to be provided "in exchange" for the Citalopram. The MAR identified Client 3 received both medications for 9 days.



2. Review of the facility policy titled “Nebulizer, Inhalers, Oxygen” (undated) identified the medication aide was to prepare and provide the inhaler to the client. Staff were to observe client doing their inhaler treatment and prompt if needed.

Review of the policy titled “Topical Medication Administration” (undated) identified medication aides would provide topical ointments, creams, sprays, and lotions. The medication aide was to ensure the client’s skin was clean and dry before application of the topical treatment. And to never touch the tub to skin or use fingers to remove ointment.

Observations on 7/10/17 at 3:00pm, 7/11/17 at 7:10am, and 7/12/17 at 8:15am found Staff A (medication aide) failed to follow facility policy and the prevailing standards for providing inhalant, topical, and instillation medications. Staff A failed to observe Client 7, Client 12, Client 15, Client 16, Client 24, Client 25, Client 30, Client 39, and Client 42 utilize their inhaler, eye drops, and/or nasal spray. When the client came to the medication room, Staff A would retrieve the client’s prescribed inhaler, nasal spray, and/or eye drop medication from the storage cart, put the medication container on the silver cart (parked in medication room doorway), and direct the client to take their medication. Staff A would then walk back to the medication cart to prepare the clients oral medications or chart on the electronic MAR. However, in doing so Staff A turned their back to the client and did not observe the client use the inhaler, eye drops, and/or nasal spray medication.

In an interview on 7/10/17 at 1:15pm, Staff A stated clients self-administered topical creams, inhalers, and eye drops, however did not self-administer oral medications.

In an interview on 7/10/17 at 5:27pm the Licensed Practical Nurse (LPN) stated there were no clients that self-administered medications.

**19-006.16E1c Provision of Medication by a Person other than a Licensed Health Care Professional:**  
***When the facility uses a person other than a licensed health care professional in the provision of medications, the facility must follow 172 NAC 95, Regulations Governing the Provision of Medications by Medication Aides and Other Unlicensed Persons and 172 NAC 96, Regulations Governing the Medication Aide Registry.***

***The facility must establish and implement policies and procedures:***

- 1. To ensure that medication aides and other unlicensed persons who provide medications are trained and have demonstrated the minimum competency standards specified in 172 NAC 96-004;***
- 2. To ensure that competency assessments and/or courses for medication aides and other unlicensed persons are provided in accordance with the provision of 172 NAC 96-005.***
- 3. That specify how direction and monitoring will occur when the facility allows medication aides and other unlicensed persons to perform the routine/acceptable activities authorized by 172 NAC 95-005 and as follows: a. Provide routine medication; and b. Provision of medications by the following routes: (1) Oral which includes any medication given by mouth including sublingual (placing under the tongue) and buccal (placing between the cheek and gum) routes and oral sprays; (2) Inhalation which includes inhalers and nebulizers, including oxygen given by inhalation; (3) Topical applications of sprays, creams, ointments, and lotions and transdermal patches; (4) Instillation by drops, ointments, and sprays into the eyes, ears, and nose.***

**4. That specify how direction and monitoring will occur when the facility allows medication aides and other unlicensed persons to perform the additional activities authorized by 172 NAC 95-009, which include but are not limited to:**

**a. provision of PRN medication;**

**b. provision of medications by additional routes including but not limited to gastrostomy tube, rectal, and vaginal; and/or**

**c. documented in client records.**

**5. That specify how competency determinations will be made for medication aides and other unlicensed persons to perform routine and additional activities pertaining to medication provision.**

**6. That specify how written direction will be provided for medication aides and other unlicensed persons to perform the additional activities authorized by 172 NAC 95-009.**

**7. That specify how records of medication provision by medication aides and other unlicensed persons will be recorded and maintained.**

**8. That specify how medication errors made by medication aides and other unlicensed persons and adverse reactions to medications will be reported. The reporting must be: a. Made to the identified person responsible for direction and monitoring; b. Made immediately upon discovery; and**

**c. Documented in client records.**

This standard is not met as evidenced by:

Based on record review and interview the facility failed to ensure written directions for PRN (as needed) medications were developed and implemented for 8 of 10 sampled clients. (Client 2, Client 4, Client 5, Client 6, Client 7, Client 8, Client 9, and Client 10)

Findings:

The facility policy titled "Medication Aide Additional Activities Direction and Monitoring" (undated) identified a Licensed Health Care Professional would develop and implement the direction and monitoring form per client's physician orders. The direction and monitoring form was to include client name, medication order with name of medication, dose, route, frequency, dose limitations, and diagnosis. Specific instructions for the medication aide included interventions, parameters for pain or temperature, observation of side effects and reporting to the licensed health care professional.

In an interview on 7/14/17 at 11:20am, the LPN reported they utilized a template, developed by the RN, to update and revise client PRN medication direction and monitoring documents based on client specific physician's orders. Once updated the RN signed the PRN direction and monitoring document and trained the medication aides on new medication orders and changes. The LPN stated the direction and monitoring document for PRN Tylenol would identify the same side effects; however, the direction and monitoring document did not identify a client specific rationale for taking the medication, for example leg or head pain.

In an interview on 7/12/17 at 3:35pm, Staff A (medication aide) reported providing PRN medications to clients which included Tylenol, psychotropic, and sleeping medications. Staff A stated the current written directions for PRN medications were kept in a book in the medication room. These written directions were what medication aides followed to provide PRN's. Staff A stated they called the

Registered Nurse (RN) or the Licensed Practical Nurse (LPN) for permission to pass psychotropic PRN medications.

In an interview on 7/14/17 at 4:45pm, Staff C (medication aide) provided copies of the client written directions for PRN medications and stated these written directions were current and what the medication aides used when providing PRN medications.

Review of the document titled, "Direction and Monitoring Agreement Part 2" signed by the Registered Nurse (RN) for the following clients failed to include instructions for the recipient specific criteria for the provision of PRN medications by medication aides.

#### Client 2

Review of Client 2's written directions for the following PRN medications found:

1. Ibuprofen 600 milligrams (mg) to be used for "Pain-Pain scale over 4. Assess pain scale 1-10" (dated 9/15/15)

The written directions failed to clearly define what "pain" meant for Client 2 and qualify under what circumstances each medication could be provided.

2. Butalbital/APAP/Caffeine 325-50-40mg 1 cap every 4-6 hours to be used for Migraine pain (dated 11/4/16)

The Butalbital/APAP/Caffeine written directions identified a frequency range of 4 to 6 hours, which failed to specify the exact amount of time between doses.

#### Client 4

Review of Client 4's written directions for the following PRN medications found:

1. Naproxen 500mg to be used for "Pain Use Pain scale 1-10" (dated 1/22/16)
2. Ibuprofen 200mg to be used for "Pain-Assess Pain Scale 1-10" (dated 2/4/14)

The written directions failed to clearly define what "pain" meant for Client 4 and qualify under what circumstances which pain medication was to be provided.

3. Tylenol 325 mg 2 tablets to be given "Every six (4) hours"

The Tylenol 325mg failed to specify which amount of time between doses was correct, four hours or six hours.

#### Client 5

Review of Client 5's record found Client 5 had one PRN written direction and monitoring document dated 9/14/16 for Promethazine DM 100/5ml one teaspoon PO BID PRN. These written directions failed to clarify what BID meant and the amount of time between doses.

Review of Client 5's July 2017 MAR (medication administration record) found Client 5 was prescribed PRN Robafen DM Syrup 100 10/5 5 milliliters (ML) PO BID. Client 5 was provided Robafen DM a total of seven times in July 2017. However review of Client 5's record found no evidence of a written direction and monitoring document for Robafen DM.

#### Client 6

Review of Client 6's written directions for the following PRN medications found:

1. Tylenol 500mg 2TS PO Q 4hr MAX dose 4000mg/24 hours, for pain use scale 5-10 (dated 6/14/2014)
2. Tylenol 500mg 2TS PO Q 4hr for pain, use scale 5-10 (dated 3/17/2016)
3. Tramadol 50mg 1-2 Tabs PO 4-6 hours, for pain, use pain scale 1-10, contact nurse prior to giving (dated 9/2/2016)
4. Tylenol #3 1-2 Tablets PO Q 4 hours, for pain use scale 7-10, contact nurse prior to giving (dated 3/17/2016)

The four written directions listed above failed to clearly define the pain parameters for Client 6 when using a pain scale range from 1-10 or 5-10. In addition, the written directions failed to direct medication aides if the pain medications could be used simultaneously.

5. Benadryl 25mg 1 T PO QD daytime hours-for allergies/EPS symptoms (extrapyramidal symptoms, drug induced movement disorders) (dated 3/15/2017)

The Benadryl written directions do not identify what the EPS symptoms may look like, and what would constitute provision of the medication if those symptoms were observed.

The PRN notes on the July MAR reported Client 6 received Diphenhist (Benadryl) per direction of the RN for anxiety on 7/7/2017. However, the written directions did not stipulate Diphenhist (Benadryl) was given for anxiety.

#### Client 7

Review of Client 7's written directions for the following PRN medications found:

1. Tylenol 325 mg 1 Tab TID PO PRN for pain, use 1-10 scale (dated 8/27/2014)
2. Naproxen 250 mg 1 TAB PO BID for pain/inflammation (dated 12/14/2016)
3. Guaifensesin Syrup DM/10 ML PO QID for cough (dated 4/1/2012)

The written directions failed to clearly define the pain parameters for Client 7 when using a pain scale range from 1-10. In addition, the written directions failed to direct medication aides if the pain medications could be used simultaneously.

Additional record review of Client 7's July 2017 MAR found Client 7 had been prescribed PRN Q-Tussin DM SYP 100-10/5 10 ml PO BID for cough. However, review of Client 7's record found no evidence of a written direction and monitoring document for Q-Tussin DM.

Client 8:

Review of Client 8's PRN written directions dated 11/13/13 found Acetaminophen 325mg was to be used for "Pain Scale 1-10." However, the written directions failed to clearly define what "pain" meant for Client 8.

Client 9:

Review of Client 9's written directions for the following PRN medications found:

1. Zinc Oxide Ointment to be used for rash. (dated 10/226/16)

The prn directions failed to describe what sign and symptoms (color, spots, chaffing, and/or size) would identify Client 9 had a rash.

2. Miralax 17gm for constipation and "No BM Noted" (dated 10/226/16)
3. Biscolax rectal suppository for constipation (dated 10/226/16)

The directions for the use of Miralax and Biscolax failed to identify the time period without a bowel movement before use of the prn.

4. Acetaminophen 325mg to be used for "Pain Scale 1-10." (dated 11/13/13)

The written directions failed clearly define what "pain" meant for Client 9.

Client 10:

Review of Client 10's written directions for the following PRN medications found:

1. Tylenol 325mg to be used for "Generalize pain. Use pain scale 1-10" (dated 2/1/16)
2. Nabumetone 750 mg to be used for "Pain-Pain scale over 4. Assess pain scale 1-10" (3/25/16)
3. Tylenol #3 "1-2 Tablets PO TID hours PRN Pain. Use pain scale 5-10" (must call nurse before giving) (3/25/16)

Review of Client 10's record found written directions for the above three PRN medications failed to clearly identify and define "pain" meant for Client 10 and qualify under what circumstances each medication could be provided. The Tylenol #3 failed to specify a medication dose.

In an interview on 7/10/17 at 5:27pm the Licensed Practical Nurse (LPN) stated there were no clients that self-administered their medications.

***19-006.16E3 Reporting of Medication Errors: The facility must have policies and procedures for reporting any errors in administration or provision of prescribed medications. Any variance from the five rights must be reported as an error:***

- 1. To the clients licensed practitioners;***
- 2. In a timely manner upon discovery;***
- 3. By written report.***

This standard is not met as evidenced by:

Based on observation, record review and interview the facility failed to document and report medication errors of variance from the five rights for 3 of 3 clients (Client 3, Client 35 and Client 50). This had the potential to effect all 52 clients who resided at the facility.

Findings:

Review of the facility policy "Medication Administration Policy", (undated) under section, Medication Errors identified if a medication error occurred, the medication aide was responsible for contacting the prescribing health care professional immediately upon discovery and to document the error on the clients MAR (Medication Administration Record)

Interview with LPN on 9/22/2017 at 9:00am, the LPN reported the following: staff were trained to contact the LPN or the RN when a med error occurred. The LPN or the Administrator/RN would then report the error to the client's physician. Staff were to identify issues with the medication provision by documenting their initials on the MAR on the date and time the medication was to be given with a circle around their initials and document on the last page of the MAR the issue with the medication. The circle of initials would alert other staff there was an issue with the medication and to review the last page of the MAR for further information. The LPN identified when the staff used the word "out", or "not in" the medication was not available in the facility to be provided to the client.

Interview with the Administrator/RN on 7/11/2017 at 2:45pm a request was made for records of facility medication errors that occurred between 6/1/16 to 7/10/2017. The Administrator/RN reported the facility had not had any medication errors during this time period.

However the following medication errors were identified during the survey and had not been documented and reported to the clients licensed practitioners:

#### Client 3

Observation on 7/10/2017 at 1:15pm, heard Client 3 asked Staff A whether Client 3's Risperidone had been delivered to the facility. Client 3 told Staff A that Client 3 had not had their Risperidone for several days. At 1:22pm Staff A, the only staff on duty, told Client 3 that Staff A would check on it.

Observation of the 2:00pm medication pass provided by Staff A, found there was no Risperidone available for Client 3. Follow-up review of the MAR for that dosage time found Staff A identified Risperidone was "out". Interview with Staff A at this same time found the Risperidone was not available and the entry in the MAR of "out" meant not available. No documentation in the MAR explaining why the medication was not available.

On 7/10/2017 at 4:06pm, Staff A was heard to tell Client 3 the Risperidone was not going to be taken that day as the pharmacy closed at 4:25pm.

Review of Client 3's medication administration record (MAR) found Client 3 was to have one 2mg tablet 3x a day of Risperidone (8am, 2pm and 9pm). Documentation on the MAR identified that the medication was "out" (not available) at 8am, 2pm and 9pm on July 7, 8 and 9 2017. The MAR documented the 8am and 2pm dosage on 7/10/17 was "out" and the 9pm dosage entry was blank.

Review of Client 3's medical record found a physician order dated 7/3/17 initially prescribing Tetrabenzine 12.5mg. However, review of Client 3's July 2017 MAR found no documentation that Tetrabenzine was provided from 7/3/17 date of order to 7/10/17 (date of review of the MAR).

The same physician order dated 7/3/17 discontinued Citalopram 10mg, 1 x daily at 8:00am and prescribed Zoloft 50mg 1x daily at 8:00am in exchange of the Citalopram. However review of Client 3's July 2017 MAR found the facility provided Client 3 the newly prescribed Zoloft 50mg in addition to the discontinued Citalopram 10mg from 7/3/17 date of order to 7/10/17 (date of review of the MAR).

The facility failed to identify these medication errors and report to Client 3's physician.

#### Client 35

Review of Client 35's July 2017 MAR found Client 35 was prescribed Mirtazapine Tab 15mg at ODT(1 tablet once daily); 1 T SL Q HS (sublingual; every night at bedtime). The documentation on the MAR identified staff provided the Mirtazapine on 7/1 -7/10/2017. However review of the last page of the MAR identified the medication was "out" (medication not available in the facility) on July 1, 2, 4, 5, 6, and 8, 2017. There was no documentation on the last page that the medication was not available on July 3 and 7, however there was documentation that the medication was not available the day prior to and after each of these dates.

Client 35 was prescribed Lidocaine Cre 4% UD (as directed) BID (twice a day) at 8:00am and 8:00pm. The documentation on the MAR identified staff provided the medication twice a day on 7/1-7/10. However, the last page of the MAR identified the medication was "out" (medication not available in the facility) on: 7/2/17-pm, 7/6/17-am &pm, 7/7/17-am; 7/10/17-am. There was no documentation in the MAR explaining why the medication was not available.

The facility failed to identify these medication errors and report to Client 35's physician.

#### Client 50

Review of Client 50's July 2017 MAR identified Client 50 was to have one 5mg tab of Cialis 1x daily at 8:00am. Documentation on the MAR, recorded the medication was provided 7/1-7/10/2017. However the last page of the MAR identified the medication was "out" (medication not available) on July 2<sup>nd</sup>, 3<sup>rd</sup>, and the 7<sup>th</sup>. The last page of the MAR reported the medication was never taken on the 5<sup>th</sup>, 6<sup>th</sup> and the 10<sup>th</sup>. There was no documentation that the medication was not available on July 4<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup>, however there was documentation the medication was not available or had never been taken the days prior and the days after each of these dates.

The facility failed to identify this medication error and report to client 50's physician.

***19-006.19B Discharge Plan: Within the first 30 days of admission a discharge plan must be developed including:***

- 1. Plan for follow up or continuing care; and***
- 2. Documentation of referrals made for the client.***

This standard is not met as evidenced by:

Based on record review and interview the facility failed to implement discharge plans within 30-days of admission for 1 of 1 new admissions reviewed. (Client 3)

Findings:

Review conducted on 7/14/17 of Client 3's record found Client 3 was admitted to the facility on 6/6/17 had been at the facility for 39 days. However, Client 3's record contained no evidence the facility had developed or implemented a discharge plan for Client 3 that documented referrals and continuation of care and treatment.

Review of the facility policies titled "Discharge Plan" (undated) and "Client Admission Policy" (undated) found a discharge plan would be developed and implemented within 30-days of admission to the facility. This plan was to address treatment after leaving the facility and include resources, referrals, and areas of concern in regards to the client's care and treatment.

In an interview on 7/13/17 at 2:40pm, the Administrator stated within the first 30-days of admission the facility's treatment team assessed the client's strengths and needs, and then developed the Individual Service Plan (ISP) and discharge plan.

***19-006.21 Safety Plan: The facility must have a system to identify and prevent the occurrence of hazards to clients. Examples of hazards to be identified and prevented are: dangerous substances, sharp objects, unprotected electrical outlets, extreme water temperatures, and unsafe smoking practices.***

This standard is not met as evidenced by:

Based on record review, observation and interview the facility failed to ensure compliance with the Nebraska Clean Indoor Air Act and facility policy prohibiting smoking in the building.

Findings:

Nebraska Revised State Statute 71-5731. Nebraska Clean Indoor Air Act.

A proprietor of a place of employment or public place where smoking is prohibited under the Nebraska Clean Indoor Air Act shall take necessary and appropriate steps to ensure compliance with the act at such place.



Nebraska Revised State Statute 71-5733. A person who smokes in a place in violation of the Nebraska Clean Indoor Air Act is guilty of a Class V misdemeanor for the first offense and a Class IV misdemeanor for the second and any subsequent offenses. A person charged with such offense may voluntarily participate, at his or her own expense, in a smoking cessation program approved by the Department of Health and Human Services, and such charge shall be dismissed upon successful completion of the program.

A proprietor who fails, neglects or refuses to perform a duty under the Nebraska Clean Indoor Air Act is guilty of a Class V misdemeanor for the first offense and a Class IV misdemeanor for the second and any subsequent offenses.

Each day that a violation continues to exist shall constitute a separate and distinct violation.

Review of the facility policy titled, Smoking Policy, (undated), identified residents are strictly prohibited from smoking in the building/rooms/bathrooms. All cigarette butts shall be disposed of in a properly designated smoking receptacle, which shall be fireproof. If a resident is deemed "unsafe" to handle their own cigarettes, the staff will immediately secure such items and will pass out cigarettes hourly and will light the individual's cigarettes. This policy shall be set forth to ensure safety for all with no exceptions to be made. Residents are allowed to carry their own cigarettes and matches if they are deemed to be safe and follow the smoking policy.

Interview with the Administrator on 7/12/17 at 5:31pm reported, Life Quest was a non-smoking facility, clients do not smoke in their room or their smoking paraphernalia is confiscated.

Interview with Client 9 on 7/12/17 at 8:52am reported when Client 9 does not feel good, Client 9 smokes inside.

Interview with Client 24 on 6/8/17 at 9:00am reported there were clients who smoked in their bedrooms and staff were aware that Client 11 smoked in their room all of the time.

Interview with client 25 on 6/8/17 at 10:41am reported there were clients who smoked in their bedrooms and staff were aware that Client 11 smoked in their room all of the time.

Interview with Client 39 on 7/12/17 at 3:38pm reported some clients smoke in their bedrooms.

Interview with Staff A on 7/12/17 at 10:00am reported clients who had been caught smoking in their room had their cigarettes and matches kept in the medication room as discipline. Second interview with Staff A at 3:35pm found staff A was aware that Client 5 and Client 11 smoke in their room on a regular basis.

Review of a sign posted in the medication room dated 6/9/17 identified the following clients had been caught by staff to be smoking in their bedrooms:

Client 5 --7/10/17 at 9:30am

Client 9 – 6/13/17 at 8:00pm

Client 23 – 6/13/17 at 6pm and 6/26/17 at 6:00am

Client 26 – 6/16/17 at 10:00am and 7/10/17 at 10:15am

Client 30 – 6/14/17 at 4:00am

***19-006.22 Environmental Services: The facility must provide a safe, clean and comfortable environment for clients which allows the client to use his/her personal belongings as much as possible. Every detached building on the same premises used for care and treatment must comply with these regulations.***

***19-006.22A Housekeeping and Maintenance: The facility must provide housekeeping and maintenance to protect the health and safety of clients.***

***19-006.22A1. Facility's buildings and grounds must be kept clean, safe and in good repair.***

This standard is not met as evidenced by:

*Based on record review, observation and interview the facility failed to ensure all parts of the premises were clean, safe and in good repair.*

Findings:

Observations conducted found the following:

1. Toilets

Bathroom between bedroom 1 and 2

Observation on 6/7/17 at 9:00am found the white toilet had brownish orange color around the caulking at the base of the toilet and the toilet seat had an orange color on the right hand side of the toilet 3" to 4" long. There was hair on the bowl and seat of the toilet.

Observation on 7/12/17 at 10:00am found the caulking stained brownish orange around the entire base and the toilet seat was an orange color on the right side of the seat.

Bathroom between bedroom 3 and 4

Observation on 6/7/17 at 9:05am found the flooring had yellow and brownish orange stains around the base of the toilet. The wall to the left and back of the toilet had yellow stains on the bottom 12" on the side wall and splatters on the back wall.

Bathroom between bedrooms 5 and 6

Observation on 6/7/17 at 9:10am found the caulking around the base of toilet had been applied unevenly and had peeled away from the base of the toilet which allowed water seepage onto the flooring beneath the toilet.

Bathroom between bedrooms 7 and 8

Observation on 6/7/17 at 10:00am found the floor had dark orange and brown stains on the flooring around the entire base of the toilet where the base was attached to the floor. The bolts which secured the toilet to the floor were rusted, dark orange in color and loose.

Observation on 7/11/17 at 7:00pm found the floor had orange and brown stains where the toilet was attached to the floor and the bolts were dark orange, loose and rusted. The right side of the toilet seat had a dent in the seat approximately 3" long.

Bathroom between bedrooms 10 and 11

Observation on 6/7/17 at 9:40am found orange and brown stains around the base of the toilet where it attached to the floor. There were long brown streaks on the underside of the toilet seat.

Bathroom between bedrooms 12 and 13

Observation on 6/7/17 at 9:45am found the caulking had turned from white to gray around the base of the toilet. The flooring around the toilet had nine dime sized orange and brown stained divots around the base of the toilet.

Observation on 7/13/17 at 9:05am found the bathroom to look the same as in the previous observation.

Bathroom between bedrooms 14 and 15

Observation on 6/7/17 at 9:50am found the floor and caulking around the base of the toilet had yellow and orange stains. Underneath the toilet seat and on the rim were brown spots with debris. Paint was coming off the sides of the seat and the seat had yellow and brown stains dried on the seat. The sink bowl had brown and orange debris in the sink and the sink failed to attach firmly against the wall as there was a gap approximately 1" wide. The drain plug for the sink was found where the sink pulled away from the wall.

Bathroom between bedrooms 16 and 17

Observation on 6/7/17 at 9:52am found the tub and surrounding floor tile were stained orange, and the caulking along the top edge of the tub and at the joint where the tub met the floor was stained orange, brown and black. The grout around each of the back splash tiles for the tub was stained black.

Observation on 7/12/17 at 8:52am found the bathroom tub/sink and toilet condition remained unchanged.

Bathroom between bedrooms 18 and 19

Observation on 6/7/17 at 9:55 found dark brown debris spattered over the entire toilet rim and under the toilet seat. There were yellow, orange and brown substances running down the lip of the toilet rim and onto the floor creating an area which was 5" x 6" and also included dark brown residue. The same residue was found at the base of the toilet from the front to the back of the toilet. The toilet bowl was spattered with spots of brown colored residue. Two items of clothing were also covered with brown substances and were laid on the floor next to the base of the toilet. A brown smear was located on the wall next to the toilet which ran down the wall 3" to 4".

Observation on 7/12/17 at 10:30am found the toilet rim under the toilet seat had hair and spattered dark brown spots of debris. The underside of the toilet lid and the underside of the seat had spattered yellow spots. Interview with Client 27 on 7/12/17 at 10:30am reported that staff had talked with them about the need to clean the bathroom and we cleaned it.

Bathroom between bedrooms 20 and 21

Observation on 6/7/17 at 10:00am found the flooring was dark orange and brown around the entire base of the toilet.

## Shower Room 2

Observation on 6/7/17 at 9:45am found the lid for the toilet tank was approximately 2 inches too short for the tank.

Observation on 7/12/17 at 10:00am found the toilet tank lid had been replaced. However, the mirror over the vanity had a crack the full width of the mirror, which was new since the 6/7/17 observation.

## Annex Residential Building

### Bedrooms 1 and 2

Observation on 6/7/17 at 11:00am found the paint on the seat of toilet was worn away from the back to the front 2 to 3 inches. The flooring around the base of the toilet was discolored and stained. A blue green rug in front of the toilet was stained with brownish orange stains in a 1' by 1' square directly in front of the toilet.

### Bedrooms 3 and 4

Observation on 6/7/17 at 9:10am found the once white caulking had turned to brownish orange and black around the base of the toilet; and pieces were missing which allowed seepage under the toilet base.

### Bedrooms 7 and 8

Observation on 6/7/17 at 10:00am found the caulking around the entire base of the toilet had turned from white to brownish orange and black.

## **2. Sinks**

### Main Building

#### Bedroom 18 & 19

Observation on 6/7/17 at 10:05am found the edge of the sink bowl was brown on the left side of the sink and the silver faucet was coated with a grayish-brown film which covered the spout, handle and base. The inside of the sink bowl was brownish orange.

#### Bedroom 21

Observation on 6/7/17 at 10:15am found yellow and brown stains in the sink bowl and the rim of the sink had orange and brown stains spattered on the rim.

### Annex

#### Bedroom 1 & 2

Observation on 6/7/17 at 11:05am found yellow and orange stains in the sink bowl 1/4<sup>th</sup> of the way up on the sides of the bowl..

## **3. Showers**

### Main building

### Shower Room 1

Observation on 6/7/17 at 9:30am found Shower Room 1 had a shower stall and a bathtub. The shower stall was 4' x 4' square had a green shower curtain and a shower chair. The walls and floor were covered with blue ceramic tiles. The blue tiled wall of the shower nozzle was partially painted a peach-white color 10 tiles high by 8 tiles wide. Half of the painted area was also stained yellow. In addition, the entire lower 8" of the shower wall was covered with a thick black substance. The joint where the wall met the floor also had the black substance on the wall. There was a black shower mat on the floor of the shower stall which had piles of thick black hair caught in the mat. The wall outside of the shower stall was missing tiles at the base of the wall and had signs of water damage along the tiles and baseboard.

Observation on 7/12/17 at 3:30pm found the shower curtain had been removed from Shower Room 1, and the hair had been disposed of, however the staining and damage had not been addressed.

### Shower room 2 - Laundry

Observation on 6/7/17 at 9:40am found a 4' wall which partially enclosed an area used for showers by clients. The area was 10' x 5' and was designed for two separate showering areas, however, one of the shower heads had been blocked off. The gray painted floor of the shower had paint chipped away around the drain as well as brown and orange stains. The floor under the working shower head was covered with a black mat, however chipped paint areas were visible through the holes in the mat. There were brown and orange stains found along the joint between the wall and the floor as well as in the grout for the ceramic tile which covered the inside of the shower wall. There was water observed leaking under the wall of the shower area and at the entry way which caused orange and brown stains to the grout, caulking and ceramic floor tiles.

Observation on 7/12/17 at 3:30pm found the mirror over the vanity to have a crack in the glass from the bottom right corner of the glass to the top left side of the mirror. Interview with the Administrator on 7/13/17 at 3:30pm reported that the glass had been broken at least one month.

## Annex

### Bedrooms 1 and 2

Observation on 6/7/17 at 11:00am found the shower stall had yellowish orange stains which surrounded the drain in the floor of the stall on all sides. In addition, a brownish-black and orange substance was found inside the door frame at the bottom.

Observation on 7/12/17 at 11:05am found the shower remained unchanged.

### Bedrooms 3 and 4

Observation on 6/7/17 at 11:05am found brown and orange stains on the inside of shower from the floor of the shower stall and up from the shower floor 3". Stains were also on the outside along the door frame and on the outside next to the shower stall base.

Observation on 7/12/17 at 11:10am found the shower remained unchanged.

### Bedrooms 5 and 6

Observation on 6/7/17 at 10:20am found the shower stall floor had a yellow and orange substance found 3 inches up from the floor on all four walls. Caulking around the stall base and the shower was caked on with orange, brownish-black substance that was also on the inside door frame. Outside of the door frame had the same color substance that ran from the hinge side of the door to 7 inches across the front of the door. Yellowish-orange brown stains and substance discolored the caulking between the floor and the stall base. In addition, the same substance was found caked between the wall and the stall base as well as behind the plastic floor board and up the bathroom door frame 2”.

Observation on 7/12/17 at 11:15am found the shower stall remained unchanged from observations on 6/7/17.

#### Bedrooms 7 and 8

Observation on 6/7/17 at 10:30am found yellow and orange stains found on the floor of the shower stall and a brownish-orange substance ran the length of the shower door frame.

### **4. Bedroom floors/walls**

#### Main building

##### Bedroom 2

Observation on 6/7/17 at 9:05am found the wall behind the headboard and the wall next to the side of the bed had spots dried on with streaks that ran down the wall and behind the bed. There was an approximate 8” x 14” area with 8 black streaks approximately 8 inches long. A second area towards the head of the bed and another at the end of the bed, brownish-gray in color had streaks running down the wall approximately 18 inches long. Underneath the bed was a large yellowish-brown stain which could be seen underneath the edge of Client 28’s bed from a standing position, and there was a brown stain on the floor approximately 2” x 4” long.

Observation on 7/12/17 at 10:00am found the wall next to Client 28’s bed was the same as the observation on 6/7/17.

##### Bedroom 12

Observation on 6/7/17 at 9:45am found the floor to the right and left side of the air conditioner, underneath the bed and in front of the dresser had a brown stain dried on the floor in multiple places. In the corners were dirt and debris build up on the floor boards. The air conditioner and window sill were covered with dirt/dust.

##### Bedroom 18

Observation on 6/7/17 at on the floor between the air conditioning unit and the wall, found the sealant used around the unit was black, coated with dust and grime; and had pulled away 4” from the wall.

Observation on 7/12/17 at 10:30am found the bedroom floors and walls to be coated with dirt/dust around the room.

##### Bedroom 19

Observation on 6/7/17 at 10:05am found the floor between the air conditioning unit, the wall and the floor area directly beneath the air conditioner on the right hand side was covered with black debris and

dirt. The floor was discolored a brownish-orange. The air conditioner and the window sill above the air conditioner had a film of dust and dirt.

Observation on 7/13/17 at 9:21am found the floors, shelves and walls to be coated with dirt/dust around the room.

#### Annex residential building

##### Bedroom 6

Observation on 6/7/17 at approximately 10:15am found the carpeting visible around and under the bed was covered with a thick dark substance (which covered approximately 85% of the floor area). The substance made the carpeting feel slick when walking. The window blinds hanging behind the bed were broken and missing slats. All blinds were covered with dust and debris. Observation on 6/8/2017 found the carpeting was replaced at approximately noon by maintenance.

Interview with Maintenance on 6/8/17 at 10:08am reported the carpet had been replaced in bedroom 6 several times.

##### Bedroom 7

Observation on 6/7/17 at 10:00am found the carpeting in front of the bed had a dark brown stain, 3'x 3" and a stain shaped like a shoe print directly in front of it.

Observation on 7/12/17 at 11:10am found the stain in the carpet remained unchanged.

#### **5. Odor**

Client 1 denied Staff C's request to allow surveyors to conduct a room observation of Client 1's room on 6/7/17 and 7/12/17.

Observation on 7/13/17 at 2:30pm found Client 1's bedroom door standing open with Staff E inside. Surveyor noticed four food trays setting on a chest which had not been returned to the kitchen. From the hallway, the surveyor noticed an odor of rotten food.

#### **B. Commons Areas:**

##### **1. Carpeting**

Carpeted Areas of the facility were observed to not be clean:

#### Main building

East hallway

Observation on 6/7/17 at 9:46am found the hallway carpet was a medium blue and had a patterned design, however the carpet was stained brownish-black in front of client doors and along the walls on either side of the hallway.

Observation on 7/12/17 at 10:00am found the hallway carpeting had been cleaned which improved the hallway area in front of client doors. However, the stains had partially returned and were light gray in color.

### Annex residential building

#### Back doorway

Observation on 6/7/17 at approximately 11:00am a 4' x 4' dark gray mat with a slight nap was placed inside the back door of the Annex. The mats edge was ripped away from 3 of 4 edges. The nap had been worn completely away in a section that ran diagonally across the middle of the mat. The mat buckled and would not lay flat, which presented a trip hazard to anybody entering the annex.

Observation on 7/12/17 at 11:00am found the mat at the annex door to be in the same condition.

#### Living room

Observation on 6/7/17 at 11:03am found the carpet in the living room area had a 3'x 4' black mark that continued in a trail to the sleeping areas. Clients and maintenance reported the black mark was spilled pop. Maintenance stated they had attempted to clean the carpets, but this stain would return.

Observation on 7/12/17 at 11:00am found the living room area to look the same as observation on 6/7/17.

Interview with Staff A on 7/12/17 at 11:00am reported being unaware that staff were to assist clients with cleaning their rooms.

Interview with Staff C on 6/7/17 at 9:30am reported the clients were supposed to keep their own rooms clean.

## **2. Kitchen**

Observation of the kitchen (which served the annex and main facility) found the following:

#### Fryer

Observation on 6/7/17 at 10:40am found the Henny Penny Pressure Fryer 600 deep fat fryer (approximately 4' tall) had a build-up of grease where the edge met the sides. There were drips marks and streaks of old grease with debris observed from the top edge of each side down all sides of the fryer. Grease build-up was also observed around the top edge which was an area 12 inches wide. The entire right side of the fryer was greasy to the touch. The two metal legs on the right hand side were covered with a brownish substance. There was oil sitting in the fryer which was not covered. A timer gauge on the front of the fryer had a white substance caked on the dial. The clear round timer cover was filmy and appeared greasy. The OFF button was caked with a red dried on liquid. The Temperature Dial/faceplate was stainless steel was greasy to the touch and had flecks of debris that had dried onto the plate and the top of the fryer. The top of the fryer also had a lip around the edges which lead to the



back of the unit and held the grease and fryer baskets. The steel wall that held the fry baskets and grease had dark brown marks along the bottom 1 – 1 ½ inches in height.

Observation on 7/13/17 at 11:50am found the deep fryer remained unchanged in appearance from the observation on 6/7/17.

#### Stove top

Observation on 6/7/17 at 10:22am found the stainless steel stove/oven was six feet long, had six burners and a 4' x 3' grill area that was covered with two upside down cookie sheet pans. The two cookie sheets had a dark brown and black substance on the sides of the pans that appeared greasy with some brown marks splattered on the bottom of the pans. The front panel of the stove had four knobs for the burners covered with grease and cooking debris splatter. All knobs, fronts, oven doors and handles were greasy to the touch. The right hand side of the stove had gas burners with two large metal stock pots. The front pot was covered with black from the attached handles down to the bottom.

Observation on 7/13/17 at 11:50am found the stove/oven remained unchanged in appearance from the 6/7/17 observation.

#### Oven racks on floor

Observation on 6/7/17 at 10:25am found the two oven racks for the oven were sitting on the floor next to the side of the refrigerator. The racks were made of silver colored metal however the one shorter rack was black and greasy to the touch. The other steel rack was silver with brown stains along the edges of the rack.

Observation on 7/13/17 at 11:50am found the racks in the oven. They were black and greasy to the touch.

#### Stove front

Observation on 6/7/17 at 10:25am found underneath the oven doors there was a black floor mat, the same as the black mats found in the shower areas of the facility. Underneath both ovens there were four air vents. The vents and oven door area and knobs were greasy to the touch and shiny because of the grease. There were long streaks of spills or grease on the front approximately 4" to 8" inches long and the knobs were caked with food debris.

Observation on 7/13/17 at 11:50am found the stove/oven remained unchanged in appearance from the 6/7/17 observation.

#### Inside oven

Observation on 6/7/17 found the inside the left oven door, the bottom of the oven was covered with a charcoal gray coating. There was white, and brown spots splattered on the bottom. The oven door was a dark gray in color and had long strands of light gray ash marks on the door and on the bottom half of the door. The inside of the oven door had brown stains on the left side approximately 5 inches long and on the right side approximately 3 inches long. Inside the right oven door was a large pan of food being heated for lunch which had aluminum foil on top. The oven had black charcoal droppings on the oven floor.

Observation on 7/13/17 at 11:50am found the stove/oven remained unchanged in appearance from the 6/7/17 observation.

Interview with Staff E, (Cook) on 7/13/17 at 11:50am confirmed that the oven/stove was dirty and needed to be cleaned.

Review of document titled Job Description-Cook; which was undated, identified the cook was responsible for ensuring the cleanliness and safety of the kitchen at all times.

Review of the facility policy and procedure titled, "Environmental Services Life Quest" (undated) identified:

- Life Quest shall keep the facility clean, neat, safe, good repair, and odor free at all times.
- All client rooms are to be cleaned weekly by the client. Staff are to assist if necessary to ensure cleanliness.
- Floors are to be kept clean, smooth and in good repair to promote well-being of the clients.
- Proper maintenance shall be maintained to ensure that repairs are done in a timely manner.

***19-006.22A3 All garbage and rubbish must be disposed of in a manner as to prevent the attraction of rodents, flies and all other insects and vermin. Garbage and rubbish must be disposed of in a manner as to minimize the transmission of infectious diseases and minimize odor.***

This standard is not met as evidenced by:

Based on record review, observation and interview the facility failed to dispose of garbage and rubbish to prevent the attraction of pests; and odors.

Findings:

Review of the facility policy titled, "Environmental Services Life Quest" (undated) identified all trash and debris is to be removed from the outside premises to ensure rodent control.

#### A. Pests

Observation of the back of the facility, on 6/7/2017 at 11:00am found the cement patio littered with various kinds of bones and other food debris. The garbage cans outside on the patio were overflowing with bottles, cans, food scraps, bags and fast food containers, some of which had spilled out on to the patio as there were no lids.

Interviews with clients smoking and seated outside on the patio during the observation stated the bones were pork chop and chicken bones from different meals during the week. The clients stated they brought left-overs from every meal out to the patio to feed the stray cats.

#### B. Odors

On 7/13/2017 at 2:30pm, Client 1's door was open to the hallway. Through the doorway, the observation found Client 1 had a chest of drawers visible which had a stack of four food trays with

partially eaten plates of food. The strong odor coming from the room into the hallway smelled of decaying food.

Review of Client 1's record found Client 1's, one treatment goal was to address Client 1's hoarding.

Requests made on 6/7/2017, 6/8/2017 and 7/12/2017 of staff to inspect Client 1's bedroom, found Client 1 refused access to their room on all three dates.

Observations and Interviews with Volunteer A and Staff B on 7/11/2017 and 7/12/2017 respectfully found both carried meal trays to Client 1's bedroom. Both Staff B and Volunteer A reported staff deliver a food tray to Client 1 for every meal as Client 1 ate all of their meals in Client 1's bedroom. There was no pick up of food trays observed. Food trays are not routinely picked up from Client 1's bedroom as it was observed to be four food trays in Client 1's bedroom.

***19-006.22A4 The facility must maintain and equip the premises to prevent the entrance, harborage, or breeding of rodent, flies, and all other insects and vermin.***

This standard is not met as evidenced by:

Based on record review, observation and interview, the facility failed to implement measures to prevent the entrance, breeding and spread of bed bugs potentially affecting all clients who resided at the facility.

**Findings:**

Interview with the Administrator on 7/13/17 at 8:05am found the facility did not have a policy or develop and implement a written plan for the prevention of bed bugs.

Review of facility records found a letter dated June 8, 2017 from an exterminating company that identified monthly pest control and inspections and bedbug heat control had been done at the facility since November 2016.

Based on observation and interviews the facility has had a history of bedbugs and continued to have bedbugs at the time of the survey.

Review of Quality Assurance Meeting notes dated 5/31/17 and 11/29/16 identified the facility had issues with bedbugs.

Observation throughout the survey (7/10 -7/14) found a mattress located outside the facility near the east hallway exit. Interview with Staff A on 7/12/17 found the exterminator company had inspected this mattress to see the extent of the bed bug infestation of the mattress.

Interview with the Administrator on 7/11/17 at 2:45pm and 3:00pm found bedbugs had been found in two bedrooms. Bedroom room shared by Client 18 and 34, and bedroom shared by Client 36 and Client 28.

The Administrator reported an exterminating company had been called to heat treat both bedrooms.

Based on interview of the exterminating company representative on 7/13, the exterminator did not arrive for treatment until 7/13/17 approximately 12:00pm.

Interview with Client 18 on 7/13/17 at 10:04am reported being asked to bag up all of their possessions to be ready to have their room to be heat treated for bedbugs.

Observation of the east hallway, outside bedroom 20, on 7/11/17 at 10:04am found Client 18's personal items had been removed from bedroom 20 and were on the floor of the hallway, where the Administrator reported bedbugs had been found. Items included for example: white large laundry hamper with no lid overflowing with items such as sheets, blankets with a pillow on top, large open black trash bag full with clothing visible, black trash can with toiletry items visible on top. At other observations the comforter, sheets and pillowcase were wadded up on the floor. Observations found that Client 34's items who shared a room with Client 18, remained inside bedroom 20.

Interview with Staff A on 7/13/17 at 3:35pm found five live/crawling bedbugs on Client 9's pillow in their bedroom.

Observation of the facility's "East Hallway" floor plan found bedroom 9 was located four bedrooms to the east of bedroom 20. When heat treatment was provided, bed bugs were found in bedroom 9.

#### Interviews

Staff B reported on 6/8/17 at 10:48am we had a bedbug problem months ago. The exterminating company came in and three rooms had to be heat treated. Staff B reported that three clients had received bedbug bites.

Client 12 reported on 6/9/17 at 11:17am that Client 12 woke up and saw something crawling on Client 12. Client 12 told Staff A that Client 12 had bites and reported nothing was done about it until they learned the bed bugs were in other rooms.

Client 19 reported on 6/9/17 at 9:49am that Client 19 had bedbugs in bedroom 21 and on Client 19's bed. Client 19 reported having had bedbug bites and went to sleep on the couch in the rec room in the past.

Client 2 reported on 6/9/17 at 9:35am Client 2 had bedbugs on their bed in bedroom 21 and stated Client 2 had seen around 15 bedbugs in their room. In the last couple of weeks, Client 2 reported they had seen seven bedbugs in bedroom 21.

Client 2 reported on 7/10/17 at 4:20pm in May their room had to be treated for bed bugs due to bed bugs coming from bedroom 20.

Client 25 reported on 6/8/17 at 10:41am about two to three months ago Client 25 had bedbugs in bedroom 14 and the bedbugs were crawling on Client 25 and in Client 25's bed.

Client 50, who lives in the Annex, reported on 7/10/17 at 6:00pm that Client 50 only went to the main building for medication and meal times due to the outbreak and traveling of bed bugs in the main building. Client 50 stated they feared getting bed bugs in their bedroom.

Client 35 reported on 7/11/2017 there currently were no bedbugs in bedroom 6 as it had been treated, but reported there had been bedbugs in their bedroom in the past.

Interview with Staff A on 7/12/2017 at 3:35pm found Staff A had seen a couple live bedbugs. One being in bedroom 20 and the other one crawling on Client 12.

Interview with Staff A on 7/13/17 at 1:15pm found Exterminators had been out 7/13/17 to spray for bedbugs. When they went into Client 9's room there were live bed bugs in the room.

Interview with the Administrator on 7/13/17 at 8:05am reported that an exterminator company would be heat treating Client 9's room as Staff A saw bed bugs in Client 9's bedroom on 7/13/17.

Review of the 7/12/17 "Service Contract" between the exterminator company and Life Quest found no evidence of a plan to eradicate all bed bugs from the facility and implement a prevention plan to prevent the entrance, breeding and spread of any and all insects and vermin into the facility.

***19-006.22C1 The facility must establish and implement procedures for the storage and handling of soiled and clean linens.***

This standard is not met as evidenced by:

Based on observation, record review and interview the facility failed to provide appropriate storage and handling of soiled and clean linens.

Findings:

Review of the facility policy titled "Procedure for Handling Soiled and Clean Linen Life Quest" (undated) found all soiled linen must be covered and kept on the "dirty side" of the laundry room to prevent mixing soiled and clean laundry. Soiled linens must put in containers specified for soiled linen and never be placed on the floor. Clean linen should never be placed back in the same receptacle that held soiled linens. Clients and staff must wear gloves at all times and thoroughly wash their hands after each contact with laundry. Only one client's clothing may be washed at a time. Clean linen should not be on the floor of the linen closets.

Observation on 6/6/17 at 11:15am and 7/13/17 at 2:20pm of the facility's laundry room found:

1. No designated or distinct areas or receptacles identifying or differentiating storage of clean and soiled linens and/or client clothing.
2. No directions or procedures regarding the handling, washing, and drying of soiled or clean laundry and linens.
3. No gloves, hand soap or sanitizer, and paper towels were available for personal protection and hand washing purposes for dealing with soiled laundry.
4. No evidence the facility provided clean and non-absorbent receptacles or washable laundry bags to prevent cross-contamination and infection control.
5. On 7/13/17 laundry sat on the floor in two piles approximately three feet tall and three black garbage bags full of linens. Additional linens were piled on top of the three black garbage bags. A pile of linens approximately one foot tall sat on top of one of the washing machine. A white laundry basket full of wet clothing and linen items sat on the countertop next to the metal sink. A blue basket filled with clothing and linens sat on a two tiered white wooden shelving unit. The same white wooden shelving unit held linens, towels, and washcloths piled and scattered haphazardly on each shelf. A two foot pile of unfolded linens was piled and scattered on a beige countertop with lower black cupboards near the dryer.
6. The metal rinse sink and large white ceramic basin rinse sink each had orange, black and brown streaks (0.5 to 2 inches in length) and splatter marks (pen cap to quarter sized) on the sides and

interior. The white basin sink held standing water that was cloudy and a light orange and brown color.

In an interview on 7/13/17 at 2:20pm (in the laundry room) Client 45 reported the wet clothing in the white laundry basket belonged to Client 4, was clean and Client 45 was waiting to put Client 4's wet clothes into the dryer. Client 45 stated they thought the piles of linens and clothing on the floor were dirty but did not know who the items belonged to. When asked if the other linens and items on the shelving units and in the black garbage bags were clean or soiled, Client 45 shrugged their shoulders and reported they did not know and were unable to identify if these linens were clean or soiled. Client 45 reported due to the recent bed bug outbreak they had been washing linens, facility laundry, and other client's linens and laundry the evening of 7/12/17 and this morning. When asked if gloves or other protective gear was provided and available for use in the laundry room, Client 45 shook their head no.

In an interview on 7/13/17 at 11:30am the Administrator identified linens were stored in a closet in the west hallway and another closet located in east side of the facility in the dining room. The Administrator stated they kept each closet stocked with sheets, pillow cases, and blankets that were clean, in good repair, and available to all clients residing at the facility.

However, observation on 7/13/17 at 11:30am (conducted with the Administrator) found the facility stored clean linens in the west and east linen closets, however could not ensure the items were stored in a clean and organized manner. Both linen closets contained stacks of bed sheets, pillow cases, blankets, and other linens rolled up in balls, unfolded, and piled haphazardly on the shelves. The east closet had more than ten linen items laying on the dirty and dusty closet floor. When the Administrator opened the east closet door further, additional linens fell off of the shelves and on to the dirty floor. The Administrator picked up these linens off of the floor, shook them causing dirt and debris to fall off, refolded the linens, and put them back on the closet shelves for client use.

***19-006.22D Pets: The facility must make certain that any facility owned pet does not negatively affect clients. The facility must have policies and procedures regarding pets that include:***

- 1. An annual examination by a licensed veterinarian that include, at a minimum, current rabies vaccinations for dogs, cats and ferrets;***
- 2. Vaccinations as recommended by the licensed veterinarian that include, at a minimum, current rabies vaccinations for dogs, cats, and ferrets.***
- 3. Provision of pet care necessary to prevent the acquisition and spread of fleas, ticks and other parasites; and***
- 4. Responsibility for care and supervision of the pet by facility staff.***

This standard is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure safety in maintaining stray cats on the premises.

Findings:

Review of the facility policy titled Pet Policy (undated) identified the facility allowed small animals, however the client (owner) needed to assume the physical and financial pet responsibility. All cats and dogs must be spayed or neutered and have a Veterinarian conduct an annual exam to assure the pet is

free from disease and parasites. All pets must be vaccinated and have routine checkups as deemed necessary by Life Quest.

The policy failed to address the health issues with non-client owned cats found on the premises

Observation conducted on 6/7/17 at 9:00am with Staff C found a yellow tabby cat inside the facility. Approximately fifteen minutes later, the yellow tabby cat was observed to be asleep on Client 12's bed in Bedroom 7. Observations during the survey conducted 7/10/17 through 7/14/17 found the yellow tabby cat continued to be on the premises but remained outside of the facility with the other cats. Interview on 6/7/17 at 9:00am Staff C reported the yellow tabby cat did not belong to any of the clients or the facility and was not supposed to be inside the facility.

Observation on 7/10/17 at 1:15pm found one orange, two black and white, and a one gray colored cats laying on the ground and sidewalk at the facility's front entrance. Another three cats laid in the grass next to the facility's west wing and another two cats on the driveway. Observation at 6:00pm, found outside the Annex (residential building) main entrance six cats laying on the cement, on the lawn furniture. The cats were observed to eat and drink from bowls outside both buildings.

Observation on 7/11/17 at 6:50am found two black and white cats at the facility's front entrance and three cats were in the grass area between the facility's main building and the Annex building. Observation at 12:30pm found ten cats laying and walking in the grass and driveway between the facility's west wing and the Annex building.

Observation on 7/12/17 at 7:48am found three cats at the facility's front entrance laying on the cement between Client 13, Client 24, and Client 48's feet while another cat walked between the grass and sidewalk.

Observation on 7/13/17 at 10:20am found two cats at the facility's front entrance laying on the cement. Another six to eight cats walked and laid in the grass area between the facility's west wing and the Annex building.

Observation on 7/14/17 at 8:15am found three cats at the facility's front entrance. Observation at 10:30am found eight cats laying and eating from the metal pan at the Annex building front entryway and another four cats laid in the grass. When Client 44 opened the Annex main door a gray cat went inside and ate cat food from a small plastic bowl located inside. Client 44 let the cat take a few bites of food then nudged it back out of the door.

Record review found the facility had no evidence the cats that were not owned by clients had received an examination by a licensed veterinarian and had current vaccinations.

Observation of the Annex building on 6/7/17 at 11:00am, 7/11/17 at 9:00am, and 7/14/17 at 11:07am found a black, red and white 40 pound bag of Kent brand cat food sitting against the wall inside the main entrance to the Annex building. This was the same cat food found in the pans located outside of the Annex's front entrance.

Interviews on 7/12/17 at 3:02pm and 7/14/17 at 11:05am with Client 50, found Client 50 and the other clients residing in the Annex building fed and watered the cats. Client 50 reported the Administrator/Registered Nurse (RN) purchased the 40 pound bags of cat food from the local feed store for the cats. Client 50 reported the cats go to the bathroom all over the grass which prevented Client 50 and others from walking in the grass as they would get cat feces on their shoes.

Interview on 7/14/17 at 10:30am with Client 8 found a gray three-legged cat on the sofa, Client 8 stated this cat belonged to Client 45, however the cats outside belonged to "all of us." Client 8 pointed to the big bag of cat food near the Annex building front entrance and stated the Administrator/RN purchased the cat food for the outside cats.

Interviews on 7/12/17 at 4:29pm and 7/14/17 at 10:55am with Client 45 found Client 46 owned the three legged gray cat. Client 45 reported they purchased treats for the cat, however the Administrator/RN purchased the big bag of cat food for clients to feed the cats outside.

In interviews on 6/8/17 at 10:08am and 7/11/17 at 2:40pm, the Administrator/RN reported the cats outside did not belong to the facility or a specific client. The Administrator/RN stated the cats stayed around the facility because the clients fed them left overs and bought cat food even though "we've told them not to feed the cats." The Administrator stated the pet policy was current.

The Administrator/RN provided veterinarian shot records for Client 45's cat and Client 24's dogs, however reported they had no evidence the outside cats were examined by a veterinarian or had current shots.



