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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 10/24/17 through 10/26/17, was conducted 12/13/17 through 12/14/17. Corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. One complaint was investigated during this survey. The census in this 114 certified bed facility was 105 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 101 through 113).	{F 000}		
{F 164} SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all	{F 164}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/2018

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information contained in the resident's records, regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review the facility staff failed to ensure personal privacy was provided for 1 of 13 Residents, Resident #102.

The findings included:

For Resident #102 the facility staff failed to provide personal privacy during a PEG (percutaneous endoscopic gastrostomy) tube medication administration and dressing change.

Resident #102 was admitted to the facility on 04/22/11 and readmitted on 04/10/16. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes

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mellitus, arthritis, dementia, and glaucoma.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/09/17 coded the Resident as 3 out of 15 in section C, cognitive patterns. This is an annual MDS.

On 12/13/17 at approximately 1020, surveyor observed LPN #1 and RN #1 administering medications via PEG tube to Resident #102 during a medication pass and pour. Resident #102's PEG dressing was also changed at this time. Both nurses entered Resident #102's room, closed the door but did not close the blinds to the outside window. During the medication administration/dressing change, Resident #102's midsection was exposed.

Surveyor requested and was provided with a copy of a policy entitled "Privacy" which read in part "Policy: It is the policy of The Company to give all Residents the opportunity for privacy. Procedure: 2. Residents' privacy will always be respected".

The concern of not providing privacy for the Resident was discussed with the administrative team during a meeting on 12/154/17 at approximately 1130.

No further information was provided prior to exit.

2. The facility staff failed to protect private health care information on 1 of 3 units, the dementia unit.

The facility staff failed to close/cover the electronic medication administration record (eMARs) containing personal health care information while staff was not in attendance for

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{F 164}	Continued From page 3 15 of 30 residents on the dementia unit. During the initial tour on 12/13/17 beginning at 9:58 a.m. on the dementia unit, the surveyor requested a list of the current residents from the unit manager registered nurse #1. R.N. #1 was at the medication cart with fifteen resident names observed on the computer screen. R.N. #1 left the medication cart with the computer screen still visible with 12 resident names highlighted in yellow and three resident names highlighted in white. The computer screen remained visible for approximately 15 seconds. When R.N. #1 returned from obtaining a list of the residents on the dementia unit, the surveyor informed her that the computer screen with 15 resident names had been visible. R.N. #1 stated "We are not supposed to leave it up." The concern of not covering the eMAR while not in attendance was discussed with the assistant director of clinical services on 12/13/17 at 4:00 p.m. The ADCS stated she would expect staff to close the computer screen. The surveyor requested the facility policy on privacy. The policy titled "Privacy" was reviewed 12/14/17 and read in part "2. Residents' privacy will always be respected." No further information was provided prior to the exit on 12/14/17.	{F 164}		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and	F 253		

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comfortable interior;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a clean, comfortable odor free environment in 1 of 13 resident rooms (Resident #109).

The findings included:

The facility staff failed to ensure Resident #109's room was clean, comfortable and odor free.

During the initial tour on 12/13/17 beginning at 9:58 a.m. on the dementia unit with the unit manager registered nurse #1, the surveyor entered Resident #109's room with R.N. #1. The door was closed. When the door was opened, the room had a strong pervasive odor of urine. R.N. #1 stated Resident #109's roommate "pees" all the time. R.N. #1 stated he will pee in the air conditioner unit. R.N. #1 stated "he just whips it out and pees anywhere."

The surveyor observed Resident #109's room again on 12/13/17 at 3:24 p.m. Resident #109's room continued to have the same pervasive smell of urine immediately upon entering the room. The surveyor interviewed the unit manager registered nurse #1 at this time. R.N. #1 stated the roommate doesn't tell the staff when he has to void. R.N. #1 stated "he doesn't want to wet on self." During the interview, R.N. #1 was asked if Resident #109's family had any concerns about the odor. R.N. #1 stated the family had not voiced any complaints. The surveyor made a phone call to Resident #109's power of attorney on 12/13/17. The phone call went unanswered.

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The surveyor interviewed the housekeeping director (other #3) on 12/13/17 at 3:30 p.m. Other #3 stated Resident #109's roommate urinated in the heating/air conditioner unit. Other #3 stated "We have used bleach. We do our 5-7 steps every day and sometimes twice a day. We pull the trash, horizontal wipe down, clean the floors, sink, toilet seats, and paper towel holder." When the surveyor asked other #3 if she would stay in the room, other #3 stated "I wouldn't want to stay in here." The surveyor requested the 5-7 steps used in the cleaning of Resident #109's room.

The surveyor, administrator and other #3 returned to Resident #109's room at 3:33 p.m. The administrator stated "I definitely smell an odor. We can something about that."

The surveyor, the administrator, and other #3 returned to Resident #109's room on 12/13/17 at 5:45 p.m. Other #3 stated the "PTAC" unit was replaced." PTAC stands for packaged terminal air conditioner. PTACs are single, commercial grade, self-contained units installed through a wall and often found in hotels. A PTAC's compressor system both cools and heats. Information accessed at www.interstateair.com/learning-center/types-of-hvac-units/ptac-units.

The surveyor reviewed the facility "Housekeeping In-Service" on 12/14/17 at 9:27 a.m. The subject was titled "5-Step Daily Patient Room Cleaning. Purpose: To show Housekeeping employees the proper cleaning method to sanitize a patient's room or any area in a healthcare facility. 5-Step Patient Room Cleaning Procedure 1. Empty

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F 253	Continued From page 6 Trash. 2. Horizontal Surfaces-disinfected 3. Spot Clean walls. 4. Dust Mop 5. Damp Mop." The surveyor also reviewed the Housekeeping In-Service for 7 steps. The subject was "7-Step Daily Washroom Cleaning. Purpose: To show Housekeeping employees the proper method to sanitize a washroom or bathroom in a long term care facility. 7 Steps Daily Washroom Cleaning 1. Check supplies 2. Empty Trash. 3. Dust Mop Floor 4. Clean and sanitize Sink and Tub. 5. Clean and sanitize Commode 6. Spot Clean Walls and / or Partitions 7. Damp Mop Floor." Resident #109 was admitted to the facility 10/18/16 and readmitted 5/4/17 with diagnoses that included but not limited to sepsis, dysphagia, deaf-non-speaking, dementia with behavioral disturbances, depressive disorder, Vitamin D deficiency, Tinea Unguium, pneumonia, and paranoid schizophrenia. Resident #109's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/18/17 coded the resident with a BIMS (brief interview for mental status) score of 02 out of 15. The surveyor informed the administrator, the assistant director of clinical services and the corporate registered nurse of the above concern with the cleanliness of Resident #109's room on 12/14/17 at 11:29 a.m. No further information was provided prior to the exit conference on 12/14/17.	F 253		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)	F 281		

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(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review the facility staff failed to follow professional standards of practice for 2 of 13 Residents, Resident #112 and Resident #101.

The findings included:

For Resident #112 the facility staff failed to follow professional standards of practice by improperly transcribing a physician's order and documenting that a treatment had been completed when the necessary supplies to complete the treatment were not available.

Resident #112 was admitted to the facility on 10/05/17 and readmitted 11/13/17. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, depression, psychotic disorder, dysphagia, and diabetic foot.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/20/17 coded the Resident as 1 out of 15 in section C, cognitive patterns. This is a significant change MDS.

Resident #112's clinical record was reviewed on

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12/13/17. It contained a signed physician's order dated 11/30/17 which read in part "Wet to dry ¼ strength Dakin's to great toe and Achilles Q6 (every) hour". The clinical record also contained a POS (physician's order summary) for 12/01/17-12/31/17 which read in part "Cleanse area to right great toe with ¼ strength dakins, apply wet to dry treatment and cover with dressing. every 6 hours for wound management" and "Cleanse area to right posterior lower leg with ¼ strength dakins, apply wet to dry treatment and cover with dressing. every 6 hours for wound management".

The clinical record also contained a TAR (treatment administration record) for 12/01/17-12/31017 which read in part "Cleanse area to right great toe with ¼ strength dakins, apply wet to dry treatment and cover with dressing. every 6 hours for wound management" and "Cleanse area to right posterior lower leg with ¼ strength dakins, apply wet to dry treatment and cover with dressing. every 6 hours for wound management". The TAR had been signed as the treatments being completed as ordered with the exception of 12/07/17 at 12p and 6p, 12/08/17 at 12a and 6a, and 12/12/17 at 12a. The entry for 12/07/17 at 12p was coded as "3" with chart code indicating Resident was "LOA" (leave of absence). All other entries were coded with "9". Chart code "9" indicated "other/see nurses' notes".

Resident #112's progress notes were reviewed on 12/13/17 and contained entries which read in part "12/08/17 05:07 eMAR (electronic medication administration)-Medication Administration Note Cleanse area to right great toe with ¼ strength dakins, apply wet to dry treatment and cover with

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dressing every 6 hours for wound management. Dakin's solution not available. Waiting for pharmacy to deliver", "12/08/17 05:08 eMAR-Medication Administration Note. Cleanse area to right posterior lower leg with ¼ strength dakins, apply wet to dry treatment and cover with dressing every 6 hours for wound management. Dakin's solution not available. Waiting for pharmacy to deliver", "12/08/17 05:09 eMAR (electronic medication administration)-Medication Administration Note Cleanse area to right great toe with ¼ strength dakins, apply wet to dry treatment and cover with dressing every 6 hours for wound management. Dakin's solution not available. Waiting for pharmacy to deliver", "12/08/17 05:10 eMAR-Medication Administration Note. Cleanse area to right posterior lower leg with ¼ strength dakins, apply wet to dry treatment and cover with dressing every 6 hours for wound management. Dakin's solution not available. Waiting for pharmacy to deliver", "12/12/17 04:34 eMAR (electronic medication administration)-Medication Administration Note Cleanse area to right great toe with ¼ strength dakins, apply wet to dry treatment and cover with dressing every 6 hours for wound management. Dakin's solution not available" and "12/12/17 04:35 eMAR-Medication Administration Note. Cleanse area to right posterior lower leg with ¼ strength dakins, apply wet to dry treatment and cover with dressing every 6 hours for wound management. Dakin's solution not available".

Surveyor spoke with RN #1 on 12/13/17 at approximately 1420 regarding availability of Dakin's solution for Resident #112. RN #1 stated that the Dakin's solution had not been available at any time and that she thought it was because the facility was waiting on approval for the Dakin's

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from the Resident's insurance. Stated that the treatment with Dakin's was a new order from surgeon's office. Also stated that they had been using normal saline as a substitute.

Surveyor spoke with RN #1 again on 12/13/17 at approximately 1445 and requested to observe wound care for Resident #112. RN #1 stated that she was waiting on Dakin's solution to arrive from the pharmacy to do wound care.

Surveyor spoke with the BOM (business office manager) at the surgeon's office on 12/13/17 at approximately 1520 regarding Resident #112. Surveyor asked BOM to clarify the order that the surgeon had written on 11/20/17 for Resident #112. BOM stated that order was for ¼ strength Dakin's solution wet to dry dressings on right great toe and right posterior lower leg. Surveyor asked BOM if their office was aware that Dakin's solution was not available at the facility and BOM stated that they were not.

Surveyor observed LPN #2 perform wound care on Resident #112 on 12/13/17 at approximately 1550. LPN #2 had unopened bottle of Dakin's solution, which she used to clean wounds on right great toe and right posterior lower leg. She then used normal saline for the wet to dry dressings. Surveyor asked LPN #2 if the Dakin's solution had been available prior to this dressing change, and LPN #2 stated that she did not normally do the dressing changes, and it had been over a week since she had done it. She could not recall having Dakin's when she had completed dressing change previously.

Surveyor spoke with the ADON (assistant director of nursing) on 12/13/17 at approximately 1700

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regarding the availability of the Dakin's solution and the physician's order for the treatment. ADON stated that she did not know about the Dakin's not being available, nor did she know whether or not there was an issue with the Resident's insurance paying for Dakin's. ADON stated that she did not think that Dakin's solution was to be used directly on the wound and that they had always done normal saline wet to dry dressings. ADON stated that one of the nurses from the facility had accompanied Resident #112 to her appointment with the surgeon and that he would know exactly what the surgeon had ordered for treatment. Surveyor brought to the attention the difference in the original order written by the surgeon and the order on the POS. ADON stated that she had transcribed the order to the POS.

Surveyor spoke with RN #2 on 12/13/17 at approximately 1725. RN #2 stated that he had went with Resident #112 to her appointment on 11/30/17. RN #2 also stated that wound care was performed in the physician's office prior to Resident returning to the facility. Surveyor asked RN #2 if he observed wound care, and what treatment the physician had used. RN #2 stated that he had observed the wound care and the physician had cleaned the areas with Dakin's solution and applied normal saline wet to dry dressings. RN #2 also stated that this was the procedure explained to him prior to leaving the physician's office.

Surveyor spoke with the pharmacist on 12/14/17 at approximately 0820 regarding Dakin's solution for Resident #112. Pharmacist stated that Dakin's solution had not been provided by the pharmacy at any time. Also stated that Dakin's is available

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as "house stock" and would not be provided by the pharmacy.

Surveyor spoke with PA (physician's assistant) at the physician's office on 12/14/17 at approximately 0915. Surveyor asked PA if he had provided the wound care for Resident #112 during her appointment on 11/30/17 and he stated that he had. Surveyor asked the PA to describe how the wound care was to be completed and PA stated that after old dressings were removed, the wounds were cleaned with wound cleaner, then a gauze pad was saturated with Dakin's solution, the excess squeezed out and wet gauze placed in the wound and covered with a dry dressing. Surveyor asked the PA if this was the procedure explained to the nurse that had accompanied the Resident on the appointment, and PA stated that it was. Surveyor then asked the PA to clarify the treatment order, and PA stated "Apply ¼ strength Dakin's solution wet to dry dressings to right great toe and right posterior lower leg every 6 hours".

Surveyor spoke with the facility FNP (family nurse practitioner) on 12/14/17 at approximately 1015. Surveyor asked FNP if she had been made aware that Resident #112 had an order for Dakin's solution, which was not available, and had said that it was alright to substitute normal saline. FNP stated that could not recall.

Surveyor spoke with ADON on 12/14/17 at approximately 1050. ADON stated that she had been made aware that Dakin's solution had not been available since original order on 11/30/17. Stated that Dakin's had been obtained from local pharmacy on 12/13/17. Surveyor asked ADON what should she have done if the original order was not specific as to how treatment should be

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done, and ADON stated "I should have called physician's office and clarified it". Surveyor asked ADON if she had done that and she stated "No ma'am, I did not." Surveyor asked the ADON if the TAR should have been signed as the treatment having been completed, when the Dakin's was not available, and ADON stated "No ma'am, it should not."

On 12/14/17 at approximately 1015, surveyor requested and was provided with a policy entitled "Wet to Dry Dressing" which read in part "Solutions as ordered for wet dressing". Surveyor also requested and was provided with a policy entitled "Physician's Orders" which read in part "The order shall be repeated back to the physician, PA or ARNP for his/her verbal confirmation. The order is transcribed to all appropriate areas (MAR, TAR, etc.). The nurse shall sign off the orders upon completion or verification of transcription." Surveyor was also provided with a copy of "Review of Medication Pass" which read in part "Nurse documents administration of medications correctly" and "MAR/TAR is without missing documentation for any day/shift".

The concern of the Dakin's solution not being available, error in transcribing the physician's order and the treatment having been signed as completed when supplies were not available was discussed with the administrative team during a meeting on 12/14/17 at approximately 1130. The RNC (regional nurse consultant) stated that the team had already reviewed the progress notes, started education and wrote a plan of correction for this concern. RNC provided the surveyor with a form entitled "PLAN OF ACTION: following physician order related to treatments" dated

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12/13/17 which read in part "Problem: Residents returned from physician appointment with new order for change in treatment. Step I-Evaluation of System and immediate response: 1. Validated physician order. 2. Obtained Dakin's solution 3. Completed treatment as ordered 4. Attempted to contact surgeon for order clarification. Step II-How to identify other Residents. Residents with treatment orders were reviewed to ensure that all necessary meds and dressings are available. The 7p nurses to complete this monitoring and placed information on monitoring tool. Step III- What measures were put in place to prevent reoccurrence. Licensed staff educated prior to working next scheduled shift. Step IV-How to monitor to ensure the problem does not reoccurrence (sic)- Orders are reviewed in clinical meeting. TAR are reviewed in morning meeting. Unit manager will validate treatment order and the availability of supplies. This monitoring tool will be completed 2x weekly for 4 week (sic) and then weekly for 4 weeks. This information will be presented by monthly QAPI meeting to identify need for ongoing education and monitoring".

No further information was provided prior to exit.

2. The facility staff failed to follow professional standards of practice for medication administration for Resident #101. Licensed Professional Nurse #1 left Resident #101's narcotic medication (Dilaudid) at the bedside on two separate occasions. L.P.N. #1 did not follow the five rights of medication administration for Resident #101.

The Office of Licensure and Certification received a complaint on 11/29/17 that stated "L.P.N. #1 left his (Resident #101) narcotic medication Dilaudid,

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on the bedside table twice, once on 11/22/17 and again on 11/23/17. Thanksgiving and 12:00 a.m. and 4:00 a.m. which was not ever given to me. It was put on my bedside table."

The surveyor reviewed Resident #101's clinical record on 12/13/17 and 12/14/17. Resident #101 was admitted to the facility 5/15/17 with diagnoses that included but not limited to malignant neoplasm of kidney, brain, and lung, chronic pain, anxiety, nicotine dependence, and gastro-esophageal reflux disease (GERD).

Resident #101's significant change in MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/13/17 assessed the resident with a BIMS (brief interview for mental status) as 14 out of 15 in Section C BIMS Summary Score.

The surveyor reviewed the November 2017 signed physician orders. The orders read in part "Dilaudid tablet 4 mg (milligrams) (Hydromorphone HCl) Give 1 tablet by mouth every 4 hours for pain-start date 07/27/17."

The surveyor reviewed the November 2017 electronic medication administration records (eMARs). The dates and times named in the complaint were reviewed. On 11/22/17 at 2000 (8:00p.m.), the box for Dilaudid 4 mg had been marked with a check mark and initialed by L.P.N. #1. On 11/23/17 at 0000 (midnight) and at 0400 (4:00 a.m.), the boxes for Dilaudid 4 mg had been marked with a check mark and initialed by L.P.N. #1. Initialed boxes indicated the medication had been administered by the nurse at a physician ordered time. The eMAR did not indicate Resident #101 had refused the medication or had

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been asleep.

The "Chart Codes/Follow Up Codes" located at the bottom of the eMAR read in part: Follow-Up Codes---"=administered.

Under Chart Codes, sleeping was an option and was indicated by "7". None of Resident #101's medications were marked with a "7".

The surveyor reviewed the "Controlled Medication Utilization Record" for November 2017. The control sheet for Dilaudid 4 mg indicated that L.P.N. #1 administered 1 Dilaudid 4 mg to Resident #101 on 11/22/17 at 2100 (9:00p.m.), 11/23/17 at 0000 (midnight), and 11/23/17 at 0430.

The surveyor interviewed the assistant director of clinical services (ADCS) on 12/13/17 at 4:00 p.m. The ADCS stated she believed the DCS (director of clinical services) did an investigation on Resident #101's concerns that L.P.N. #1 left medication (Dilaudid) at the bedside without observing the medication being taken. The ADCS stated the DCS did that investigation. The DCS was not available during the survey 12/13/17 or 12/14/17 to interview. The ADCS stated she did not know all the circumstances surrounding the incident but L.P.N. #1 was moved to another unit. The ADCS did state that she would expect a nurse to administer medications as ordered. The ADCS stated "You do not leave medications at the bedside."

An email dated 11/24/17 to the admissions director (other #2) from Resident #101 read in part: "Dear Other #2, I hate involving you in all of this but just as I figured as soon as I turned the

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evidence over to the unit manager registered nurse #1 of Blue who advised me she would not be here well I was advised in a heated argument with registered nurse #2 the RN on duty that the pills and change of custody agreement was being turned over to the DON (name omitted) who's very good friends with L.P.N. #1 the supervisor who she rehired and gave her the title of supervisor. I also have some more evidence for you and the administrator here." Attached to the email were three pictures of medication cups with times written on tape that had been placed across the mouth of the cups. The surveyor was unable to read the wording.

The surveyor reviewed the "Employee Corrective Action Form" for L.P.N. #1 dated 11/24/17. The form read "Verbal education. Resident states meds were left in room by nurse. Employee comments read: Resident was awake when medication was placed on bedside table after knocking on resident's door. Resident was awakened by touching him on his knee and he acknowledged my presence."

The surveyor reviewed the "Employee Corrective Action Form" for L.P.N. #1 dated 11/28/17. A description of the violation read "Resident states meds were left in room by nurse at the hours of 12am & 4 am. During conversation with L.P.N. #1, she admitted that she left the Dilaudid (narcotic at the resident's bedside). L.P.N. #1 is aware that she violated medication administration policy. L.P.N. #1 is currently in a supervisory role for nursing. At this time, the supervisor role will be suspended pending further notice. L.P.N. #1 will be removed from the skilled unit until further notice. L.P.N. #1 was educated on medication administration and that L.P.N. #1 is to observe

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the resident take the medication and not leave any medication at the bedside table."

The surveyor interviewed L.P.N. #1 on 12/14/17 at 8:13 a.m. L.P.N. #1 stated that Resident #101 was awakened and that the resident acknowledged her. L.P.N. #1 stated the pills were left separate in cups--1 pill at midnight and the next one at 4:00 a.m. L.P.N. #1 stated Resident #101 didn't sleep in bed but in a lounge chair in the room. L.P.N. #1 never voiced why the medications were left on the bedside table or why the medications were not observed taken by Resident #101 in the nurse's presence.

The surveyor interviewed the unit manager registered nurse #1 on 12/14/17 at 9:42 a.m. R.N. #1 stated she received the Dilaudid in two separate cups. Resident #101 had taken a picture of them. Resident #101 told R.N. #1 that L.P.N. #1 did not awaken him for his medications and left the meds on the bedside table. R.N. #1 stated "That don't make it right. The nurse should have stayed with him. I am to start doing random rounds to observe medication passes. I have not started this yet. I am to check rooms for any loose medications or medication cups sitting around. I have not started this yet either. We have educated the nursing staff on the medication administration policy."

The surveyor informed the administrator on 12/13/17 at 4:45 p.m. of the contents of the complaint. The administrator provided an email sent from other #12 on 11/27/17 at 9:36 a.m. that read "Resident #101 stated on November 23, 2017, L.P.N. #1 came into his room to administer his Dilaudid at 12pm and 4 pm, and each time he was sleeping and she left the Dilaudid on his

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bedside table, without waking him up. Resident #101 stated this is a federal offense because anyone could have come into his room and taken his medication. Resident #101 stated he took pictures of the Dilaudid and put the Dilaudid in the refrigerator. Resident #101 stated he sent the pictures and an email to the admissions coordinator (other #2) to make her aware of the incident. Resident #101 stated the unit manager, administrator, and DON (director of nursing) were made aware of the incident and spoke with L.P.N. #1. Resident #101 stated all L.P.N. #1 received was "a slap on the hand." Resident #101 stated R.N. #1 informed the resident L.P.N. #1 would be shadowed beginning 11/26. We need to do a thorough investigation of Resident #101's comments and ensure we have a plan in place related to all of this." The administrator stated the resident said one thing and the nurse involved said another. The administrator stated the nurse was counseled and is a staff nurse now.

During the interview concerning the complaint investigation, the administrator stated L.P.N. #1 did not follow standards of practice for medication administration. When the surveyor asked if L.P.N. #1 failed to follow the facility policy for medication administration and their standard of practice, the administrator stated "That is correct."

The surveyor informed the administrator, the assistant director of clinical services and the corporate registered nurse on 12/14/17 at 11:29 a.m. of the concerns with the medication administration of Resident #101's Dilaudid on 11/22/17 and 11/23/17 involving L.P.N. #1.

The surveyor reviewed the facility policy on

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F 281	Continued From page 20 medication administration titled "Medications-Oral Administration of" on 12/13/17. The policy read "Administer oral drug and remain with resident until medication is swallowed. Check resident's mouth if in doubt. Do not leave medication at bedside." This is a complaint deficiency.	F 281		
{F 309} SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	{F 309}		

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and the residents' goals and preferences.

(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review the facility staff failed to follow physician's orders for 1 of 13 Residents, Resident #102.

The findings included:

For Resident #102 the facility staff failed to follow physician's orders for PEG (percutaneous endoscopic gastrostomy) tube dressing change.

Resident #102 was admitted to the facility on 04/22/11 and readmitted on 04/10/16. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, arthritis, dementia, and glaucoma. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/09/17 coded the Resident as 3 out of 15 in section C, cognitive patterns. This is an annual MDS.

On 12/13/17 at approximately 1020, surveyor observed LPN #1 and RN #1 administering medications via PEG tube to Resident #102 during a medication pass and pour. Resident #102's PEG dressing was also changed at this time by RN #1. RN #1 stated that the gauze dressing around the PEG tube was wet and proceeded to apply a dry gauze pad around the

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{F 309}	Continued From page 22 PEG site. Resident #102's clinical record was reviewed on 12/13/17 and contained a POS (physician's order summary) for December 2017 which read in part "Cleanse PEG tube site with NS (normal saline), pat dry, apply small amount of triple antibiotic ointment and cover with PEG dressing as needed for PEG management and every shift for PEG site management". Surveyor spoke with RN #1 on 12/13/17 at approximately 1215 regarding the PEG dressing and RN #1 stated "I changed the gauze just because it was saturated. I will go back a do the treatment later. If you check the treatment sheet, I haven't signed it yet". Surveyor spoke with the ADON on 12/14/17 at approximately 1040 regarding the PEG treatment. Surveyor asked ADON if gauze around the PEG site was saturated, did that indicate an "as needed" dressing change and ADON stated that it did. Surveyor then asked if RN #1 should have completed full PEG site treatment instead of just applying a dry gauze, and ADON stated that she should have. The concern of not completing the PEG treatment as ordered was discussed with the administrative team during a meeting on 12/14/17 at approximately 1130. No further information was provided prior to exit.	{F 309}		
{F 441} SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	{F 441}		

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{F 441}	Continued From page 23 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	{F 441}		

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(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review the facility staff failed to follow infection control guidelines during a dressing change for 2 of 12 Residents, Resident #102 and Resident #112.

The findings included:

1. For Resident #102 the facility staff failed to perform hand hygiene between gloves changes during a dressing change.

Resident #102 was admitted to the facility on

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04/22/11 and readmitted on 04/10/16. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, arthritis, dementia, and glaucoma. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/09/17 coded the Resident as 3 out of 15 in section C, cognitive patterns. This is an annual MDS.

On 12/13/17 at approximately 1020, surveyor observed LPN #1 and RN #1 administering medications to Resident #102 via PEG (percutaneous endoscopic gastrostomy) tube during a medication pass and pour. Resident #102's PEG dressing was also changed at this time by RN #1. RN #1 washed her hands, donned clean gloves, then removed the soiled gauze from around Resident's PEG site. RN #1 placed soiled gauze in trash can, removed soiled gloves, donned clean gloves, but did not perform any type of hand hygiene prior to donning clean gloves. RN #1 placed dry gauze dressing around PEG tube, removed gloved and performed hand hygiene.

Surveyor spoke with RN #1 on 12/13/17 at approximately 1215 regarding PEG dressing change. Surveyor asked RN #1 if she had performed hand hygiene between glove changes, and RN #1 stated that she had not. Surveyor asked RN #1 if she should have performed hand hygiene between glove changes and she stated that she should have.

Surveyor requested and was provided with a policy on 12/14/15 at approximately 1015 entitled "Hand Hygiene" which read in part "Hand hygiene should be performed: After glove removal". Surveyor was also provided with a policy on

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12/14/17 at approximately 12p entitled "Dressing Change" which read in part " Procedure: Place supplies on prepped work surface, perform hand hygiene, apply gloves, remove and dispose of soiled dressing, removes gloves, perform hand hygiene, apply gloves..."

The concern of not performing hand hygiene between glove changes was discussed during a meeting with the administrative staff during a meeting on 12/14/17 at approximately 1130.

No further information was provided prior to exit.

2. For Resident #112 facility staff failed to clean scissors prior to using them the cut a dressing.

Resident #112 was admitted to the facility on 10/05/17 and readmitted 11/13/17. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, diabetes mellitus, hyperlipidemia, depression, psychotic disorder, dysphagia, and diabetic foot.
The most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/20/17 coded the Resident as 1 out of 15 in section C, cognitive patterns. This is a significant change MDS.

Surveyor observed LPN #2 on 12/13/17 at approximately 1550 perform dressing change to Resident #112. LPN #2 cleaned over bed table, washed hands, donned gloves, placed drape under Resident's foot, removed gloves, washed hands, donned gloves, placed barrier on table, assembled supplies on table, removed dressings from pin sites and discarded, removed gloves, washed hands, donned gloves, removed dressing

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{F 441}	Continued From page 27 from right great toe and foot and discarded, removed gloved, washed hands, donned gloves, removed dressing from back of lower leg and discarded, removed gloves and washed hands. LPN #2 dated dressings, washed hands, donned gloves, cleaned suture site, applied dressing, removed gloves, washed hands, and donned gloves, cleaned wound to great toe, then LPN #2 the placed gloved hand in her pocket, removed scissors, placed on barrier, opened gauze, used scissors to cut gauze, saturated gauze with normal saline and placed gauze into wound and covered with dry dressing. LPN #2 did not clean scissors prior to use. Surveyor spoke with the ADON on 12 /137 at approximately 1700. Surveyor asked ADON if LPN #2 should have cleaned her scissors prior to using them and ADON stated that she should have. Surveyor requested and was provided with a policy entitled "Dressing Change" on 12/14/17 at approximately 12p which read in part "Procedure: Assemble equipment needed for dressing change: gloves, wound cleaner/normal saline, tape, gauze, scissors, applicators.....Place supplies on prepped work surface..." The concern of not cleaning the scissors was discussed with the administrative team during a meeting on 12/14/17 at approximately 1130. No further information was provided prior to exit.	{F 441}		
{F 514} SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	{F 514}		

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{F 514}	Continued From page 28 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure a complete and accurate record for 1 of	{F 514}		

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13 residents (Resident #101).

The facility staff failed to ensure Resident #101's electronic medication administration record (eMAR) and the "Controlled Medication Utilization Record" were accurate.

The Office of Licensure and Certification received a complaint on 11/29/17 that stated "L.P.N. #1 left his (Resident #101) narcotic medication Dilaudid, on the bedside table twice, once on 11/22/17 and again on 11/23/17. Thanksgiving and 12:00 a.m. and 4:00 a.m. which was not ever given to me. It was put on my bedside table."

The surveyor reviewed Resident #101's clinical record on 12/13/17 and 12/14/17. Resident #101 was admitted to the facility 5/15/17 with diagnoses that included but not limited to malignant neoplasm of kidney, brain, and lung, chronic pain, anxiety, nicotine dependence, and gastro-esophageal reflux disease (GERD).

Resident #101's significant change in MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/13/17 assessed the resident with a BIMS (brief interview for mental status) as 14 out of 15 in Section C BIMS Summary Score.

The surveyor reviewed the November 2017 signed physician orders. The orders read in part "Dilaudid tablet 4 mg (milligrams) (Hydromorphone HCl) Give 1 tablet by mouth every 4 hours for pain-start date 07/27/17."

The surveyor reviewed the November 2017 electronic medication administration records (eMARs). The dates and times named in the

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complaint were reviewed. On 11/22/17 at 2000 (8:00p.m.), the box for Dilaudid 4 mg had been marked with a check mark and initialed by L.P.N. #1. On 11/23/17 at 0000 (midnight) and at 0400 (4:00 a.m.), the boxes for Dilaudid 4 mg had been marked with a check mark and initialed by L.P.N. #1. Initialed boxes indicated the medication had been administered by the nurse at a physician ordered time. The eMAR did not indicate Resident #101 had refused the medication or had been asleep.

The "Chart Codes/Follow Up Codes" located at the bottom of the eMAR read in part: Follow-Up Codes---"=administered.

Under Chart Codes, sleeping was an option and was indicated by "7". None of Resident #101's medications were marked with a "7".

The surveyor reviewed the "Controlled Medication Utilization Record" for November 2017. The control sheet for Dilaudid 4 mg indicated that L.P.N. #1 administered 1 Dilaudid 4 mg to Resident #101 on 11/22/17 at 2100 (9:00p.m.), 11/23/17 at 0000 (midnight), and 11/23/17 at 0430.

The surveyor interviewed the assistant director of clinical services (ADCS) on 12/13/17 at 4:00 p.m. The ADCS stated she believed the DCS (director of clinical services) did an investigation on Resident #101's concerns that L.P.N. #1 left medication (Dilaudid) at the bedside without observing the medication being taken. The ADCS stated the DCS did that investigation. The DCS was not available during the survey 12/13/17 or 12/14/17 to interview. The ADCS stated she did not know all the circumstances

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surrounding the incident but L.P.N. #1 was moved to another unit. The ADCS did state that she would expect a nurse to administer medications as ordered. The ADCS stated "You do not leave medications at the bedside."

An email dated 11/24/17 to the admissions director (other #2) from Resident #101 read in part: "Dear Other #2, I hate involving you in all of this but just as I figured as soon as I turned the evidence over to the unit manager registered nurse #1 of Blue who advised me she would not be here well I was advised in a heated argument with registered nurse #2 the RN on duty that the pills and change of custody agreement was being turned over to the DON (name omitted) who's very good friends with L.P.N. #1 the supervisor who she rehired and gave her the title of supervisor. I also have some more evidence for you and the administrator here." Attached to the email were three pictures of medication cups with times written on tape that had been placed across the mouth of the cups. The surveyor was unable to read the wording.

The surveyor reviewed the "Employee Corrective Action Form" for L.P.N. #1 dated 11/24/17. The form read "Verbal education. Resident states meds were left in room by nurse. Employee comments read: Resident was awake when medication was placed on bedside table after knocking on resident's door. Resident was awakened by touching him on his knee and he acknowledged my presence."

The surveyor reviewed the "Employee Corrective Action Form" for L.P.N. #1 dated 11/28/17. A description of the violation read "Resident states meds were left in room by nurse at the hours of

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12am & 4 am. During conversation with L.P.N. #1, she admitted that she left the Dilaudid (narcotic at the resident's bedside). L.P.N. #1 is aware that she violated medication administration policy. L.P.N. #1 is currently in a supervisory role for nursing. At this time, the supervisor role will be suspended pending further notice. L.P.N. #1 will be removed from the skilled unit until further notice. L.P.N. #1 was educated on medication administration and that L.P.N. #1 is to observe the resident take the medication and not leave any medication at the bedside table."

The surveyor interviewed L.P.N. #1 on 12/14/17 at 8:13 a.m. L.P.N. #1 stated that Resident #101 was awakened and that the resident acknowledged her. L.P.N. #1 stated the pills were left separate in cups--1 pill at midnight and the next one at 4:00 a.m. L.P.N. #1 stated Resident #101 didn't sleep in bed but in a lounge chair in the room. L.P.N. #1 never voiced why the medications were left on the bedside table or why the medications were not observed taken by Resident #101 in the nurse's presence.

The surveyor interviewed the unit manager registered nurse #1 on 12/14/17 at 9:42 a.m. R.N. #1 stated she received the Dilaudid in two separate cups. Resident #101 had taken a picture of them. Resident #101 told R.N. #1 that L.P.N. #1 did not awaken him for his medications and left the meds on the bedside table. R.N. #1 stated "That don't make it right. The nurse should have stayed with him. I am to start doing random rounds to observe medication passes. I have not started this yet. I am to check rooms for any loose medications or medication cups sitting around. I have not started this yet either. We have educated the nursing staff on the

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medication administration policy."

The surveyor informed the administrator on 12/13/17 at 4:45 p.m. of the contents of the complaint. The administrator provided an email sent from other #12 on 11/27/17 at 9:36 a.m. that read "Resident #101 stated on November 23, 2017, L.P.N. #1 came into his room to administer his Dilaudid at 12pm and 4 pm, and each time he was sleeping and she left the Dilaudid on his bedside table, without waking him up. Resident #101 stated this is a federal offense because anyone could have come into his room and taken his medication. Resident #101 stated he took pictures of the Dilaudid and put the Dilaudid in the refrigerator. Resident #101 stated he sent the pictures and an email to the admissions coordinator (other #2) to make her aware of the incident. Resident #101 stated the unit manager, administrator, and DON (director of nursing) were made aware of the incident and spoke with L.P.N. #1. Resident #101 stated all L.P.N. #1 received was "a slap on the hand." Resident #101 stated R.N. #1 informed the resident L.P.N. #1 would be shadowed beginning 11/26. We need to do a thorough investigation of Resident #101's comments and ensure we have a plan in place related to all of this." The administrator stated the resident said one thing and the nurse involved said another. The administrator stated the nurse was counseled and is a staff nurse now.

During the interview concerning the complaint investigation, the administrator stated L.P.N. #1 did not follow standards of practice for medication administration. When the surveyor asked if L.P.N. #1 failed to follow the facility policy for medication administration and their standard of practice, the administrator stated "That is

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correct."

The surveyor informed the administrator, the assistant director of clinical services and the corporate registered nurse on 12/14/17 at 11:29 a.m. of the concerns with the medication administration of Resident #101's Dilaudid on 11/22/17 and 11/23/17 involving L.P.N. #1. L.P.N. #1 documented the administration of Dilaudid to Resident #101 on 11/22/17 and 11/23/17 on both the November 2017 eMARs and on the "Controlled Medication Utilization Record" when the medication had not been taken by the resident.

The surveyor reviewed the facility policy on medication administration titled "Medications-Oral Administration of" on 12/13/17. The policy read "Administer oral drug and remain with resident until medication is swallowed. Check resident's mouth if in doubt. Do not leave medication at bedside. Chart on Medication Administration record (MAR) according (sic) immediately following when medication is given and before proceeding to the next resident."