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	495367	A. BUILDING _____ B. WING _____	05/26/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/24/16 through 5/26/16. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 70 certified bed facility was 67 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 3 closed record reviews (Residents 14 through 16).	F 000		
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.15(e)(1) A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility staff failed to accommodate the needs of one resident (Resident # 10) in a survey sample of 16 residents. Findings included: Resident # 11 was a 64 year old female who was admitted to the facility on 2/13/2015 with	F 246	F246 The dates of completion serve as my allegation of compliance. 1. Resident # 10 room has been monitored daily to ensure that the staff provide services to accommodate the individual needs of the residents with focus on care of personal belongings and	6/17/16

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

Electronically Signed | 06/08/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 diagnoses of but not limited to: Status Post Total Knee Arthroplasty (Knee Replacement), Hypertension, Hypercholesteremia, Osteoarthritis, Migraine Headache, Vertigo, Heart Murmur, Kidney Disease, History of unilateral Nephrectomy (Removal of Kidney), Vitamin D Deficiency and Sleep Apnea. The only Minimum Data Set (MDS) was an admission 5 day assessment with an Assessment Reference Date (ARD) of 2/20/15. The MDS coded Resident # 11 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required limited assistance with activities of daily living; always continent of bowel and bladder. On 5/25/2016 at 11:00 AM during the group interview, Resident # 10 stated the staff often do not hang up her clothes for her in a timely manner. Resident # 10 stated it has happened more than once that her clothes that were worn on Sunday were not hung up until Thursday. Resident # 10 stated she could not use her hands very well anymore and just needed assistance with hanging the clothes up sometimes. Resident # 10 stated that when she asked some of the Certified Nursing Assistants to hang the clothes up, she was told that they would get to them later. Resident # 10 stated it was days later before the clothes were hung up. Resident # 10 was coded as having contractures of both hands. There were orders for hand rolls to be placed in both hands. Hand rolls were observed in both of Resident # 10's hands during the survey.	F 246	putting personal clothing away in proper location. Staff have been educated on the importance of providing services to accommodate the needs of residents in regards to care of personal belongings. 2. All resident□s rooms have been monitored by the Director of Nursing/Designee to ensure that individual needs and/or services have been met including storing personal belongings. The Charge Nurse will be responsible for ensuring residents are receiving services to accommodate their needs on a daily basis. 3. RNs, LPNs and CNAs have been inserviced on "Accommodation of Needs". The inservice included but was not limited to the importance of the resident□s right to receive services in the facility to accommodate their individual needs, the expectation of staff to provide for these needs and identify any individual needs in accordance with Residents Rights. 4. The Director of Nurses/Designee will monitor 20% of residents rooms on a weekly basis to ensure their individual needs are being met. The Director of Nursing/Designee will report any trends or patterns to the CQI committee at least quarterly.	

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F 246	Continued From page 2 On 5/26/2016 at 11:25 AM, an interview was conducted with CNA (Certified Nursing Assistant) A who stated she was familiar with Resident # 10. CNA A stated the staff should hang the clothes up for Resident # 10. CNA A stated whichever staff member who helped the resident to take the clothes off should help to hang them up. CNA A also stated that if Resident # 10 took her own clothes off, the CNA assigned to her the next day should help to hang up the clothes if the resident requested it. An interview was conducted with LPN (Licensed Practical Nurse) A who stated she did not know there were problems with the clothes of Resident # 10 being hung up as late as four days after being worn. LPN A stated she thought the clothes were hung up within one or two days. LPN A stated Resident # 10 often undressed herself and put some of her own clothes away. LPN A stated the facility staff should help Resident # 10 with hanging up her clothes whenever requested. An interview was conducted with the Director of Nursing who stated Resident # 10 was alert and able to communicate her needs. The DON stated she was not aware of any issues with Resident # 10's clothes not being hung up timely or with staff members not hanging them up when asked by the resident. During the end of day debriefing on 5/26/2016 at 12 noon, the facility administrator, Director of Nursing and Corporate Consultants were informed of the findings.	F 246		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		6/17/16

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F 278	Continued From page 3 CFR(s): 483.20(g) - (j) The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure a complete and accurate MDS (Minimum Data Set) RAI (Resident Assessment Instrument) was done for one resident (Resident # 1) in a survey sample of 16	F 278	F 278 The dates of completion serve as my allegation of compliance. 1. The MDS for Resident # 1 with the ARD dated 12/16/2015, Section C 0100, was modified to reflect "0" No(resident is	

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F 278	Continued From page 4 residents. For Resident # 1, the facility staff failed to accurately complete "Section C: Cognitive Patterns" in a comprehensive assessment. Findings included: Resident # 1 was a 78 year old female who was admitted to the facility on 12/23/2013 with diagnoses of but not limited to: Heart Failure, Diabetes, Hyperthyroidism, Aphasia, Epilepsy, Alzheimer's Disease, History of Cardiovascular Accident (Stroke), Dysphagia, Edema and Gastrostomy Tube. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3/9/2016. The resident was coded with total assistance of one to two staff persons with activities of daily living; Resident # 1 was coded as always incontinent of bowel and occasionally incontinent of bladder. A review of the clinical record was conducted on 5/25/2016 and 5/26/2016. Review of an Annual assessment with an ARD of 12/16/2015 revealed on the MDS, page 7 of 42, Under Section C. Cognitive Patterns. C0100. Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be conducted? Attempt to conduct interview with all residents. Enter code: 0. No (resident is rarely/never understood, Skip to and complete C0700-C1000, Staff Assessment for Mental Status. 1. Yes, Continue to C0200, Repetition of Three Words.	F 278	rarely/never understood). The sections C0200-C0500 were subsequently skipped per RAI instructions. Sections C0700-C1000 were accurately coded according to RAI instructions. The RAC was reeducated on the importance of accurate completion of MDS regarding cognitive patterns. 2. The Assistant Director of Nursing/ Designee will review all MDSs completed for the past 30 days to ensure accuracy of section "C". Any variances identified will be corrected in accordance with the RAI manual. MDS staff /Designee will be responsible for ensuring accurate coding on all MDS assessments. 3. The Assistant Director of Nursing Operations/Designee will re-educate MDS coordinators on the importance of coding accuracy according to the RAI manual. 4. The Assistant Director of Nursing/Designee will review 20% of MDSs completed weekly for six weeks to ensure accurate coding of section "C". If any variances are identified, they will be investigated and/or corrected and responsible staff re-educated. The Director of Nursing/Designee will identify any patterns or trends and report them to the Continuous Quality Improvement Committee at least quarterly.	

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The facility staff entered the code 1 indicating the BIMS should have been conducted.

The code entered for C0200 Repetition of Words was "0" indicating none were correct.

For Section C0300 Temporal Orientation, Zeroes were entered for Able to report correct year, correct month and correct day of the week indication Resident # 1 was incorrect by more than 5 years, more than a month and incorrect about the day of the week.

Under C0400. Recall, dashes were coded under the ability to recall the words "sock", "blue" and "bed."

Under C0500. Summary Score was the score of 99. The instructions were "Enter 99 if the resident was unable to complete the interview."

On Page 8 of 42, Section C. Cognitive Patterns: C0600. Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? The facility staff entered the code 1 indicating "Yes (resident was unable to complete the interview)."

"Section C: Cognitive Patterns: C1000 Made decisions regarding tasks of daily life" was not coded with numbers for Resident # 1. There was a dash in that section where numbers should be listed. The options included the numbers 0, 1, 2 or 3 depending on the degree of impairment.

On 5/26/2016 at approximately 10:25 AM, the Director of Nursing (DON) was interviewed regarding the coding of dashes on the MDS in the Cognitive Patterns. The DON stated she was unsure of why dashes were coded on the MDS

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but would ask the nurses who did the assessments. The DON took the surveyor to the MDS office. Two nurses were working in the MDS office.

An interview was conducted with RN (Registered Nurse) B on 5/26/2016 at 10:30 AM who stated the Section C: Cognitive Patterns C1000: Cognitive Skills for Daily Decision Making should have been completed with a number instead of a dash. RN B stated Resident # 1 qualified for a number 3 indicating severely impaired-never made decisions.

On 5/26/2016 at 10:35 AM, an interview was conducted with the RN (Registered Nurse) Assessment Coordinator/MDS Coordinator (RN A) who stated if there are dashes under the Brief Interview Memory Status (BIMS) or Cognitive Status section C0400. Recall, "it means the resident could not complete the interview." RN A also stated she was taught to attempt an interview with every resident. RN A also stated she was "taught to put dashes in Section C0400 Recall to get the score of 99 for the BIMS (Brief Interview for Memory Status)." RN A stated Resident # 1 was not usually understood and was not capable of completing an interview so the staff had to complete the staff assessment for Cognitive Patterns for Resident # 1.

RN A and RN B stated Resident # 1 was never understood and never understands. RN B stated Resident # 1 should have been assessed by the staff for cognitive patterns because Resident # 1 was never understood and C0100 prompted the staff to code as zero and sip to complete the Staff Assessment for Mental Status section.

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Further review of another section of the MDS on page 6 of 42 revealed under B0700. Makes Self Understood was coded as a 3 indicating Rarely/Never understood and B0800. Ability to Understand Others was coded as a 3 indicating Rarely/never understands.

Review of the CMS's RAI Version 3.0 Manual Section C: Cognitive Patterns Coding Tips, October 2011, on page C-4 revealed the statement "If the interview is stopped, do the following:

1. Code -, dash in C0400A, C0400B, and C0400C.
2. Code 99 in the summary score in C0500.
3. Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?
4. Complete the Staff Assessment for Mental Status.

The RAI Manual also showed Under C1000: Cognitive Skills for Daily Decision Making (cont.) October 2015, on Page C-23, under Steps for Assessment # 4. "Focus on the resident's actual performance. Where a staff member takes decision-making responsibility away from the resident regarding tasks of every day living, or the resident does not participate in decision making, whatever is or her level of capability may be, the resident should be coded as impaired performance in decision making."

On 5/26/2016 at approximately 12:15 PM, during the end of day debriefing, the Administrator, Director of Nursing and Corporate Nurse (Admin C), and Corporate Vice President (Admin D) were informed of the findings. The DON stated the MDS assessments should be complete and

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F 278	Continued From page 8 accurate. No further information was provided.	F 278		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.20(k)(3)(i) The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for one Resident (Resident #15) in a survey sample of 16 Residents. For Resident #15, the facility staff failed to clarify a physician's order for administration of Metoprolol, a medication for hypertension. The order indicated the medication was to be held if Resident #15's diastolic blood pressure was less than 90 mmHg (millimeters of Mercury) instead of being held if the systolic blood pressure was less than 90 mmHg as desired by the physician. The findings included: Resident #15, a female, was admitted to the facility 2/2/16 and discharged home 3/23/16. Her diagnoses included nontraumatic intracranial hemorrhage, edema, encephalopathy, muscle weakness, aphagia, dysphagia, hyperlipidemia, type II diabetes mellitus, hypertension, cellulitis, hypertrophyic bone, and hemiplegia.	F 281	F281 The dates of completion serve as my allegation of compliance. 1. Resident #15 was discharged from the facility on 3/23/16 and no further action is required. The nurses have been reeducated on professional standards in regards to clarification of parameters with antihypertensive medications. 2.The medical records of residents receiving medications for hypertension have been reviewed by the Director of Nurses/Designee to ensure physician□s orders required no further clarification. The Charge Nurse will monitor all orders daily to ensure orders are complete and no further clarifications are needed. 3. LPNs and RNs have been inserviced by the Nursing Education and Training Coordinator/Designee on "Physician Orders with Parameters". The inservice included the importance of reviewing orders with the provider when obtained to	6/17/16

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F 281	Continued From page 9 Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) 2/9/16 was coded as an admission assessment. She was coded as having short and long term memory deficits and required extensive assistance with making daily life decisions. She was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of dressing. For dressing, Resident #15 was coded as needing limited assistance. Review of Resident #15's clinical record revealed a signed physician's order, "2/2/16 Metoprolol Tartrate 50 mg (milligram) tablet Notes: BP (blood pressure) and pulse hold: <55.00 Hold, Diastolic Blood Pressure is <90.00 Hold. Two times daily via gastrostomy tube." A gastrostomy tube is a soft flexible tube surgically inserted through the abdominal wall into the stomach to administer hydration, nutrition, and medication for a Resident that is unable to swallow. An accompanying entry was placed on the eMAR (electronic medication administration record) with nursing initials and blood pressure and pulse readings indicating the medication was administered twice daily. When investigating the days Metoprolol was administered when the diastolic blood pressure was less than 90 mmHg, the DON (director of nursing) stated 5/26/16 at 2:10 p.m., the order was "wrong to start with..." The DON stated the physician wanted the medication held if Resident #15's systolic blood pressure was less than 90 mmHg not the diastolic blood pressure less than	F 281	ensure order and parameters are accurate and complete as well as a review of medication classes that typically have parameters attached and type of parameters. 4. The Director of Nursing/Designee will review weekly 20% of all new physician orders for antihypertensive medications for six weeks to ensure no clarification is needed. The Director of Nursing will report any trends or patterns to the Continuous Quality Improvement Committee at least quarterly.	

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90 mmHg.

Review of the facility's policy entitled "Medication Administration Guidelines" included:

"Medications are administered in accordance with written orders of attending physicians, manufacturer's specifications, and professional standards of practice."

Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

Same source, page. 706, "Responsibility and accountability are other critical thinking attitudes essential to safe medication administration. Accept full accountability and responsibility for all action surrounding the administration of medications. When administering medications to a client, do not assume that the medication that is ordered for the client is the correct medication or the correct dose. Be responsible for knowing that the medication ordered for clients are the correct medications and the correct doses. You are responsible for administering an ordered medication that is knowingly inappropriate."

Same source, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Verify medication information whenever new MARs are written or

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F 281	Continued From page 11 distributed or when clients transfer from one nursing unit or health care setting to another. Once you determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications." The administrator and DON were informed of the failure of the staff to ensure Resident #15's order for Metoprolol with parameters to hold the medication was correct, 5/26/16 at 2:20 p.m.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview facility documentation review and clinical record review, the facility staff failed for 1 resident (Resident #8) of 16 residents in the survey sample to implement the bowel protocol. Resident #8 did not have a bowel movement during the time periods of 4/3/16 to 4/10/16, 4/12/16 to 4/20/16, 4/21/16 to 5/1/16, and 5/17/16 to 5/22/16. The bowel protocol was not implemented. The findings included:	F 309	F 309 The dates of completion serve as my allegation of compliance. 1. Resident #8's medication regimen and bowel elimination pattern was reviewed. There were no negative effects related to constipation and the resident has had no further episodes of constipation 2. The bowel movement report was reviewed for all residents to ensure that any resident not having a bowel movement in three or more days received	6/17/16

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F 309	Continued From page 12 Resident #8, an 83 year old, was admitted to the facility on 11/22/10. Her diagnoses included hypertension, failure to thrive, dysphagia, and dementia. The resident was receiving hospice services. The most recent Minimum Data set assessment was a quarterly assessment with an assessment reference date of 3/6/16. Resident #8 was coded to have a severe cognitive impairment. She was coded to require extensive assistance with activities of daily living. She was coded as not having a bowel movement during the 7 day look back period. Resident #8 was observed on 5/26/16 at 11:20 a.m. in the dining room reclined in the geri chair. She did not respond when spoken to. Resident #8's bowel movement records were requested for April 2016 and May 2016. According to the records, Resident #8 did not have a bowel movement during the following time periods: 4/3/16 to 4/10/16 4/12/16 to 4/20/16 4/21/16 to 5/1/16 5/17/16 to 5/22/16 Resident #8 did not require hospitalization or appeared to be in pain during these time periods. April 2016 and May 2016 nursing notes were reviewed. They read as follows: - 4/21/16, 5:31 p.m.: MOM (milk of magnesia) given for no BM for 72 hours, responsible party aware - 4/27/16, 2:33 p.m.: No BM noted in past 3 days.	F 309	treatment with effectiveness documented. The Charge Nurse/Designee will be responsible for reviewing the bowel movement report on a daily basis and implementing the bowel management protocol per MD order. 3. The Nursing Education and Training Coordinator / Designee re-educated the nursing staff of the importance of bowel management. The inservice included but was not limited to identifying residents at risk for constipation, implementing preventive measures and daily monitoring with review of the bowel management protocol. 4. The Charge Nurse/ Designee will review the bowel movement report daily and initiate bowel protocol as needed. The Director of Nursing / Designee will monitor findings for six weeks to identify any patterns or trends and report them to the Continuous Quality Improvement Committee at least quarterly.	

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MOM given by mouth. No results noted during shift
- 5/11/16, 1:59 p.m.: resident name on bowel list. Milk of magnesia given. No results at this time. Will continue to monitor.
- 5/23/16, 12:27 p.m.: Last noted BM on 5/16/16. Per CNA, resident had a bowel movement today.

The facility Bowel Protocol was requested. The policy "Managing Incontinence" included the section "BM Management Program." This section read:
1. Review medical record and interview resident if possible
2. Review bowel incontinence record
3. Toilet resident according to plan of care
4. Determine adequate fluid intake levels and plan of offering
5. Print BM list daily for residents with no BM for three days
6. Administer laxatives/ enemas as per physician orders
7. Assess for needed changes in the following: dietary, medications, scheduled toileting

Included was the following list of medications:
Milk of Magnesia, 30 milliliters, as needed every day
Enema, 1, as needed every day
Dulcolax 10 milligram suppository, 1, as needed every day

The Director of Nursing (DON) was interviewed on 5/26/16 at 2:30 p.m. The DON stated that the BM list was automatically populated from the information the Certified Nursing Assistants (CNA) documented in the electronic bowel record. If a resident had a small bowel movement or not had a bowel movement in 3

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F 309	Continued From page 14 days, their name would appear on the list. The DON stated that the charge nurse monitored the BM list. She stated that milk of magnesia would be administered the first day that a resident appeared on the BM list. If a bowel movement had not occurred by the next day, an enema should be administered, followed by the dulcolax suppository on the next day. According to the April 2016 and May 2016 Medication Administration Record (MAR), Milk of Magnesia was administered on the following dates: 4/20/16- effective 4/24/16- no effect 4/27/16- results not expected yet 5/11/16- no effect Resident #8 was never administered an enema during the month of April 2016 or May 2016. Resident #8's bowel movements and MARs were reviewed with the DON. The DON shared that Resident #8 did not eat much, which could contribute to the frequency of bowel movements. The DON was informed that it did not appear that the bowel protocol was implemented for Resident #8. The DON stated "something should have been done." The Administrator and DON were notified of the issue at the end of day meeting on 5/26/16.	F 309		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(c) Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		6/17/16

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F 314	Continued From page 15 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed for 1 resident (Resident #3) of 16 residents in the survey sample to identify and treat an unstageable pressure ulcer resulting in harm. On 4/1/16, a black, calloused area with defined wound edges was identified on Resident #3's left heel by a floor nurse during a weekly skin check. No treatment was initiated. The area was not assessed again by facility staff until 4/6/16. On 4/6/16, the area was documented by the wound care nurse as unstageable-100% eschar. The findings included: Resident #3, an 89 year old, was admitted to the facility on 9/18/14. Her diagnoses included congestive heart failure, hypertension, anemia, dysphagia and breast cancer. Resident #3's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date of 3/7/16. She was coded with a Brief Interview of Mental Status score of 12 indicating no cognitive impairment. She required extensive assistance	F 314	F314 The dates of completion serve as my allegation of compliance. 1. A head to toe skin assessment was performed on Resident #3 with no new alteration in skin integrity noted. The attending physician was notified of the assessment with no new orders received. Resident #3'□s plan of care was reviewed to ensure it reflected her current needs and condition. 2. The facility completed and documented a 100% skin check on all residents to ensure that all pressure ulcers had been identified accurately and interventions have been implemented. The Charge Nurse/Designee will be responsible for ensuring weekly skin checks are completed, changes in skin integrity are identified and treatment is initiated. 3. RN□s, LPN□s and CNA□s have been inserviced by the Nursing Education and Training Coordinator/Designee on Pressure Ulcers. The inservice included a review of the pressure ulcer policy, the	

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F 314	Continued From page 16 with most activities of daily living. She was coded to have no current pressure ulcers. She was not coded to be at risk for the development of a pressure ulcer. Although the MDS did not identify Resident #3 as being at risk for the development of a pressure ulcer, Resident #3 had a previous ulcer to the sacrum when she was first admitted to the facility. In addition, the form "Braden Scale for Predicting Pressure Sore Risk" was completed for Resident #3 on 1/11/16. The assessment form determined that the resident was "At Risk" for the development of a pressure sore. The care plan had the following information: Problem, 4/6/16, " (Resident) has a history and is at risk for pressure ulcers. " The following Interventions were added to the care plan on 4/6/16: -check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown -perform nutritional screening -Use pillows, pads, or wedges to reduce pressure on heels and pressure points. Turn/ reposition. -Do not massage skin over pressure areas -Blue open heeled boots to be worn while resident is in bed. Skin prep to be applied to resident ' s left heel every shift-d/c 4/7/16. 4/7/16 Betadine to L heel every shift. No shoe to left foot when resident is in wheelchair. Only non-skid socks. Resident #3 ' s care plan also addressed properly fitting shoes. The problem read " (Resident) is at risk for falls due to diagnosis of dementia (has a decreased sense of safety awareness),	F 314	importance of providing interventions to promote wound healing and prevention of pressure ulcers and initiation of appropriate treatment. RN□s, LPN□s, and CNA□s will be educated by the Nursing Education and Training Coordinator on the identification and prevention of pressure ulcers upon hire and quarterly. 4. The Assistant Director of Nursing/Designee will review 100% weekly for six weeks, of those residents with pressure ulcers to ensure that the pressure ulcers have been accurately identified and that appropriate treatment and preventative interventions have been implemented. The Director of Nursing will report any trends or patterns to the Continuous Quality Improvement Committee at least quarterly.	

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decreased mobility and a diagnosis of hemiplegia. Interventions, dated 7/14/15, included " Footware will fit properly and have non-skid soles. "

On 5/25/16 at 3:30 p.m., the wound nurse was interviewed. When asked why the facility did not code Resident #3 to be at risk for the development of a pressure ulcer on the MDS, the wound nurse stated that they did not consider her at risk because she was mobile. She stated that the Interdisciplinary Team (IDT) made this decision. The wound nurse was asked to provide documentation from the IDT. No documentation was provided.

Weekly skin checks were completed by the floor nurses. Resident #3's weekly skin checks were completed as follows:
3/4/16- no issue identified
3/11/16- no issue identified
3/13/16- skin check not completed
3/18/16- no issue identified
3/25/16- skin check not completed
4/1/16- hardened area, left heel

Licensed Practical Nurse A (LPN A) was the nurse who identified the hardened area to the left heel. She initiated the form titled "Nonpressure-Initial Skin Documentation Form for Wounds" on 4/1/16. The "wound type" was hand written in as "calloused area." The "wound color" was checked as "black." No drainage was present. The "wound edges" description was checked as "defined, fibrotic, scarred, or hyperkeratonic." The "surrounding tissue" description was checked as "black or hyperpigmented." In the comment

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section, the description "dark stable area (L) heel" was written.

On 5/26/16 at 11:40 a.m., LPN A was interviewed. LPN A was asked if she remembered doing the skin assessment of Resident #3's heel. LPN A stated that she did remember. During the interview, LPN A was asked to describe the area. She described it as "hard, rough and dry." She stated that there was no drainage present. When asked if the heel area had defined edges, LPN A stated that she could feel the edge. When asked what she meant by the description of "stable", LPN A stated that the area was not gel like. LPN A was asked if the area felt the same as the surrounding skin. She stated that she did not touch the other skin.

LPN A explained that skin areas identified during a weekly skin check were documented either on a Nonpressure form or a Pressure area form. When asked how she determined which form to use, LPN A stated that she chose to use the Nonpressure form because she was not sure what the area on the left heel was. She stated that this skin assessment was completed after hours on a Friday evening. LPN A did not inform any staff that she was unsure of her assessment of Resident #3's left heel. LPN A stated that she did not start a treatment to the area "because it was stable and I didn't feel like it needed a treatment."

LPN A was asked to explain what happened to the pressure or nonpressure form after it was completed by a floor nurse. She stated that the forms were put into the skin assessment book on the unit. The charge nurse was supposed to review the skin forms. There was no

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documentation that the charge nurse or any other nurse assessed the left heel area after LPN A put the Nonpressure form in the skin book. The next time the heel was asssessed was on 4/6/16 by the wound care nurse.

On 4/6/16, the wound care nurse assessed the left heel area. Documentation was completed on the "VHS Pressure Ulcers Initial Skin Documentation/ Assessment Form." It was documented that the wound "developed after admission" on 4/6/16. The wound was documented as "Unstageable- Slough and/ or Eschar, 100% Eschar/ Slough." Length 4, width 3.5 centimeters. Wound color: black. "Surrounding tissue: Normal for ethnic group." "Wound edges: distinct, even with wound base." The area was not documented to have any pain.

Treatment was initiated on 4/6/16, skin prep to left heel every shift. The treatment was changed on 4/7/16 to Betadine solution daily, apply betadine soaked gauze to left heel and dry dressing once daily.

On 5/24/16 at 5:25 p.m., the wound care nurse stated that 4/6/16 was the first time she assessed Resident #3's heel wound.

The wound care nurse also documented the wound in the clinical notes. Her note read: 4/6/16, 4:11 p.m. "It was noted that resident has an area of stable eschar to her left heel. Resident is at risk for skin breakdown due to comorbidities of CHF (congestive heart failure), AFIB (atrial fibrillation), HTN (hypertension), anemia, and Vit D deficiency. Resident has decreased mobility and was discharged from PT (physical therapy) on 3/23/16 where she was

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receiving therapy for bilateral heel cord flexibility to increase safety. Resident likes to get up in the early morning and is able to self propel herself around in the w/c (wheel chair). Resident is incontinent of bladder and has a few documented episodes of bowel incontinence. Resident currently consumes 75-100% of breakfast, lunch, and dinner. She is on a multivitamin for nutritional supplementation. MD (doctor) notified of request to obtain lab work to check for protein malnutrition. Blue open heeled boots to be worn while resident is in bed, skin prep to be applied each shift, and resident and staff aware that resident is only to wear non skid socks of that foot until wound heals. ____ (wound specialist) to see resident on next scheduled visit. MD and RP (responsible party) aware."

A wound care specialist evaluated the left heel wound on 4/11/16. The wound was described as pressure, unstageable necrosis. The wound size was documented as 3.5 x 3.1 x 0.1 "Thick adherent black necrotic tissue (eschar): 100%." Continue Betadine treatment.

Resident #3's wound was observed in the presence of the wound care nurse and an additional surveyor on 5/25/16 at 9:58 a.m.. The wound had a necrotic center/ cap and measured 2.5 x 2.5 (centimeters).

On 5/25/16, around 2:15 p.m., Resident #3's wound was reviewed with the DON. The DON was asked if the area, which was first identified as a callous and five days later identified as 100% eschar, was identified incorrectly by the floor nurse on 4/1/16. The DON stated that she could see how it could get identified wrong due to the resident's dark, dry skin. The DON also stated

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that education was provided to staff to help ensure that hyperpigmented skin and pressure areas get identified appropriately.

On 5/25/2016, around 2:25 p.m., the facility Wound Care Consultant stated that she reviewed the documentation for all five of the wounds in question by the survey team. She stated that she felt the treatment modalities were accurate. She stated that she agreed that the facility staff had an issue with identification and staging. The DON and wound care nurse were present during the interview.

On 5/26/16 at 1:45 p.m., the wound care nurse and Director of Nursing (DON) were interviewed. Both the wound care nurse and the DON stated that they assessed skin areas after they were identified by the floor nurses. When asked why the area to Resident #3's heel was identified on 4/1/16 (Friday) and was not assessed again until 4/6/16 (Wednesday), the wound care nurse stated that the area was identified on a Friday night and that she and the DON were not at the facility over the weekend. When asked why it was not looked at on Monday or Tuesday, the DON stated that she was on vacation from 4/4/16 to 4/8/16. The wound care nurse did not say why she did not look at the area until 4/6/16.

At this time, the wound care nurse and DON were notified that LPN A stated that she was unsure of how to assess the area to Resident #3's heel and that LPN A had not notified any staff that she questioned her own assessment of the left heel. The wound care nurse stated that she was not aware that LPN A questioned the area.

During this time, the wound care nurse and DON

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stated again that they did not feel that Resident #3 was at risk for the development of a pressure ulcer (Although the 4/6/16 note written by the wound care nurse read that the resident is at risk due to comorbidities). They stated that the resident would tell them if she had pain or any type of issue. It was reviewed with the wound care nurse and DON that the facility's initial assessment of the area did not indicate that pain was present. It was also reviewed that Resident #3 stated to this surveyor that the wound did not hurt, she did not know that she had a wound, and that she did not know how the heel wound happened. Resident #3 stated that since the development of the wound, she does not wear shoes, only gripper socks (interview 5/26/16 at 10:05 a.m.).

The wound care nurse mentioned that the wound could have been caused by the resident's shoe. When asked if the resident could put her shoes and socks on by herself, the DON stated no. It was reviewed that Resident #3 required assistance with dressing, bathing and hygiene. According to the bathing and shower record, Resident #3 received a bed bath on 4/1/16, 4/2/16, 4/4/16, and 4/5/16. No documentation was provided that showed that the staff who had administered the bed baths had identified or reported the left heel issue. During an interview on 5/24/16 at 5:25 p.m., the wound care nurse stated that certified nursing assistants were expected to report skin areas identified during daily care.

Resident #3's care plan was reviewed. The care plan read "____ is at risk for and/or has altered skin integrity." The "Interventions" read "4/6/16- impaired skin integrity to left heel- tx (treatment)

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as ordered- encourage offloading as tolerated." Other interventions included assist with turning/ repositioning, complete Braden scale per policy, educate on risks, preventions, and treatments, inspect skin and report bruises, open areas or discoloration, use positioning/ preventative devices as tolerated.

The facility policy titled "Pressure Area Prevention Program" was reviewed. "Identification of residents at risk for development of pressure ulcers" included the use of the Braden Scale to be completed with each RAI (resident assessment instrument) quarterly or comprehensive assessment. "Monitoring for effectiveness of the interventions" included "at least daily, staff should remain alert to potential changes in the skin condition of the resident and should evaluate and document the identified change."

The section "Pressure Points and Tissue Tolerance" read "Tissues closest to the bone may be the first tissue to undergo necrosis. Pressure ulcers are usually located on bony prominence, such as sacrum, heel, the greater troncanter, ischial tuberosity, fibular head, scapula and ankle. The following may need to be evaluated for at risk residents: support surfaces, positioning- postural alignment, distribution of weight, balance and stability, shoes, determine if medical device is in use (tubes, casts, orthoses, braces, cervical collars, etc., contractures."

The facility policy titled "Pressure Ulcer Treatment Program" was reviewed. Under the "Procedure" section read "CNAs (Certified Nursing Assistants) and other direct care staff should report any signs or symptoms of a potential pressure related

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impairment of skin integrity to the head/ charge nurse immediately." The section titled "Stage Determination Guidelines" read "Pressure ulcers in which the base is covered by slough are unstageable." The section "Stage Classifications" read "Unstageable Related to Slough and/ or Eschar- Pressure ulcers that are covered with slough and/ or eschar and the true depth (and therefore stage) cannot be determined." The policy defined Eschar Tissue as "dead or devitalized tissue that is hard or soft in texture; usually black , brown or tan in color and may appear scab-like; necrotic tissue and eschar are usually firmly adherent to the base of the wound and often to the sides/ edges of the wound."

The following definitions regarding pressure injuries and staging were accessed from the National Pressure Ulcer Advisory Panel website on 5/31/16 at 1:25 p.m.
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
"Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."
"Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or

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F 314	Continued From page 25 eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed." The Administrator, DON and corporate staff were notified of the harm level deficiency on 5/26/16 at 12:15 p.m.	F 314		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(d) Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, and clinical record review, the facility staff failed to ensure UTI's (urinary tract infections) were treated timely for one resident, (Resident #7) in a survey sample of 16 residents. For Resident #7, the facility staff failed to successfully obtain a physician ordered urinalysis for culture and sensitivity in a timely manner. A urinalysis and culture and sensitivity was ordered on 4-4-16, the urine was not successfully	F 315	F315 The dates of completion serve as my allegation of compliance. 1.Resident #7 was assessed by the Director of Nursing and the resident was without negative outcomes related to delay in treatment of Urinary Tract Infection. Resident #7 is without signs and symptoms of a UTI. 2. The records of all residents who have	6/17/16

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F 315	Continued From page 26 obtained and sent to the lab until 4-21-16. The results were available for review by the physician on 4-24-16, however a physician's order for treatment was not obtained until 4-25-16, and the Antibiotic, which was ordered as a result of the infection, was omitted in the middle of treatment on 4-28-16. The findings included: Resident #7 was admitted to the facility on 2-2-15. Diagnoses included, urinary tract infection, hypertension, high cholesterol, Parkinson's disease, deep vein thrombosis, and osteoporosis. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-27-16 was coded as a quarterly assessment. The Resident was coded as 11 of a possible 15 points on a "Brief Interview for Mental Status" (BIMS) assessment indicating mild cognitive impairment, and able to make needs known, and able to make daily life decisions. Resident #7 was also coded as requiring limited assistance for ambulation, and extensive assistance of one staff member for all of her activities of daily living. Resident #7 was coded as being frequently incontinent of urine, and always continent of bowel. Review of Resident #7's nursing progress notes revealed that on 4-4-16, the Resident complained of burning upon urination, and a nursing assessment described red labia. Resident #7's doctor ordered for a urinalysis, culture and sensitivity (UA/C&S) to be obtained and sent to the lab for evaluation.	F 315	had lab services in the past 30 days were reviewed to ensure that labs were obtained in a timely manner, the MD has been notified of results and reports are located in the medical record. The Charge Nurse will be responsible for daily monitoring of all labs ordered to ensure they are obtained timely, MD has been made aware and results are placed in medical record. 3. LPNs and RNs were inserviced by the Director of Nursing/Designee on Lab Services . The inservice included but was not limited to the importance of following physician orders regarding obtaining specimens, retrieving the results and notifying provider of lab results in a timely manner to aide in the prevention and treatment of urinary tract infections. 4. The Director of Nursing/Designee will review weekly 20% of labs completed for six weeks to ensure that all services are provided as ordered and results received in a timely manner. The Director of Nursing/Designee will report any trends or patterns to the Continuous Quality Improvement Committee at least quarterly.	

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Review of nursing progress notes, and Laboratory reports revealed that the urinalysis, culture and sensitivity was not obtained until the following day on 4-5-16, and it was contaminated by facility staff, so could not be completed by the laboratory. The staff was notified on 4-7-16 of the incomplete test by the lab. The doctor was not notified until 4 days later, on 4-11-16. At that time on 4-11-16 the doctor again ordered a UA/C&S, to be completed. That UA/C&S was not obtained until the following day on 4-12-16, and it was contaminated by facility staff, so could not be completed. The staff was again notified by the lab on 4-13-16 of the incomplete test. The doctor was not notified again until 4 days later, on 4-17-16. At that time the doctor again ordered a UA/C&S, to be completed. On 4-18-16 the Resident fell while trying to go to the bathroom. The third UA/C&S, was ordered by the doctor on 4-17-16 was not obtained until 4 days later, on 4-21-16. The third test was completed, and resulted, and the facility was notified on 4-24-16 at 3:40 p.m. The doctor was not notified until the following day on 4-25-16 at 4:01 p.m. that Resident #7 had a urinary tract infection, and the doctor ordered an antibiotic to treat the infection. From 4-4-16 when the Resident complained of a Urinary tract infection, to the date of treatment, was 21 days.

Review of the Physician's orders, and Medication Administration Record (MAR), revealed that "Bactrim DS 800-600 mg (milligrams) two times daily for 5 days", was ordered by the doctor on 4-25-16 to treat the urinary tract infection.

The evening dose of the Bactrim antibiotic was not signed as given on 4-28-16, and an equal sign (=) appeared on the MAR where a nurse

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would sign with her initials to indicate a medication had been given. The Registered Nurse Assistant Vice President of Operations for the facility was interviewed on 5-25-16 in the conference room by surveyors, and asked what this notation meant. Her response was, "if an equal sign appears the medication is not signed as given."

Multiple facility policies were reviewed, and stated that symptomatic signs of a urinary tract infection will be investigated and treated timely and appropriately.

The Infection Control Coordinator review was conducted on 5-26-16 at 10:00 a.m., with the person responsible for the program, Assistant Director of Nursing Registered Nurse (RN C). She stated that symptomatic signs of a urinary tract infection would be investigated and treated appropriately, and timely, as infections worsen if not treated immediately.

On 5-25-16, when interviewed, the DON (Director of Nursing) stated she had no further information regarding why the urinalysis, culture and sensitivity was not obtained in a timely manner nor why the clinician was not informed of the results in a timely manner, and for days after they were available for review.

On 5-25-16, and 5-26-16, at the end of day debrief, the administrator and DON were informed of the failure of the staff to obtain a urinalysis, culture and sensitivity effectively, and timely, and to send to the lab timely after being ordered. Also, once the results were available for review, staff did not contact the doctor timely for notification of staff failure to carry out the order.

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F 315	Continued From page 29 Once Resident #7 was diagnosed with a urinary tract infection, the staff further failed to administer the antibiotics as ordered resulting in a missed dose, which was never completed. The facility Administration stated they had no further information to present.	F 315		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.25(l) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		6/17/16

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F 329	Continued From page 30 by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure one Resident (Resident #15) in a survey sample of 16 Residents was free from unnecessary medication. Metoprolol Tartrate 50 mg (milligram) two tabs was not administered per physician's orders. The order stated to hold the medication if Resident #15's diastolic blood pressure was less than 90 mmHg (millimeters of Mercury) and the staff administered it when her diastolic blood pressure was less than 90 mmHg. The findings included: Resident #15, a female, was admitted to the facility 2/2/16 and discharged home 3/23/16. Her diagnoses included nontraumatic intracranial hemorrhage, edema, encephalopathy, muscle weakness, aphagia, dysphagia, hyperlipidemia, type II diabetes mellitus, hypertension, cellulitis, hypertrophyic bone, and hemiplegia. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) 2/9/16 was coded as an admission assessment. She was coded as having short and long term memory deficits and required extensive assistance with making daily life decisions. She was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of dressing. For dressing, Resident #15 was coded as needing limited assistance. Review of Resident #15's clinical record revealed a signed physician's order, "2/2/16 Metoprolol	F 329	F329 The dates of completion serve as my allegation of compliance. 1. Resident #15 was discharged from facility on 3/23/16 and no further action required. There were no negative outcomes related to unnecessary medications. Nurses were reeducated on the importance of following physician orders in regards to holding medication in conjunction with prescribed parameters. 2. The medical records of residents receiving medications for hypertension have been reviewed by the Director of Nursing/Designee to ensure medications are being held according to prescribed parameters. The Medication Nurses will be responsible for ensuring medications are administered according to prescribed parameters on a daily basis. 3. LPNs and RNs have been re-educated on "Unnecessary Medications". The inservice included but was not limited to the importance of following parameters prescribed with use of anti-hypertensive medications, notifying MD when results are consistently outside of those parameters and/or with a change in resident status or condition. 4. The Assistant Director of Nursing/Designee will review 20% of medication administration records weekly	

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F 329	Continued From page 31 Tartrate 50 mg (milligram) tablet Notes: BP (blood pressure) and pulse hold: <55.00 Hold, Diastolic Blood Pressure is <90.00 Hold. Two times daily via gastronomy tube." A gastronomy tube is a soft flexible tube surgically inserted through the abdominal wall into the stomach to administer hydration, nutrition, and medication for a Resident that is unable to swallow. An accompanying entry was placed on the eMAR (electronic medication administration record) with nursing initials and blood pressure and pulse readings indicating the medication was administered twice daily. Review of the eMAR revealed Resident #15 was administered Metoprolol 50 mg two tabs on the following days and times when her diastolic blood pressure was less than 90 mmHg: 2/5/16 morning diastolic 66 mmHg 2/7/16 morning diastolic 61 mmHg 2/8/16 morning diastolic 71 mmHg 2/9/16 morning diastolic 64 mmHg 2/12/16 evening diastolic 84 mmHg 2/14/16 morning diastolic 51 mmHg 2/19/16 morning diastolic 66 mmHg 2/20/16 morning diastolic 64 mmHg 2/22/16 morning diastolic 76 mmHg 2/23/16 morning diastolic 64 mmHg 2/25/16 morning diastolic 63 mmHg 2/27/16 morning diastolic 62 mmHg 3/1/16 morning diastolic 78 mmHg 3/2/16 morning diastolic 75 mmHg 3/3/16 morning diastolic 79 mmHg 3/6/16 morning diastolic 61 mmHg 3/8/16 morning diastolic 50 mmHg	F 329	for six weeks to identify residents currently receiving anti-hypertensive medication with parameters. The audit is to ensure prescribed parameters are being followed and residents are free from unnecessary medication. The Director of Nursing will report any trends or patterns to the Continuous Quality Improvement Committee at least quarterly.	

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3/9/16 morning diastolic 68 mmHg
3/10/16 morning diastolic 67 mmHg
3/11/16 morning diastolic 62 mmHg
3/12/16 morning diastolic 68 mmHg
3/16/16 morning diastolic 71 mmHg
3/17/16 morning diastolic 59 mmHg
3/17/16 evening diastolic 76 mmHg
3/18/16 morning diastolic 67 mmHg
3/19/16 morning diastolic 62 mmHg
3/20/16 morning diastolic 71 mmHg
3/21/16 morning diastolic 71 mmHg
3/22/16 morning diastolic 55 mmHg.

When interviewed, the DON (director of nursing) stated the physician's order was incorrect and should have been for the medication to be held if the systolic blood pressure was less than 90 mmHg, however the order was a physician's order and should have been followed, 5/26/16 at 2:10 p.m.

Review of the facility's policy entitled "Medication Administration Guidelines" included:

"Medications are administered in accordance with written orders of attending physicians, manufacturer's specifications, and professional standards of practice."

Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

The administrator and DON (director of nursing) were informed of the failure of the staff to follow

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F 329	Continued From page 33 physician's orders by administering Metoprolol when Resident #15's diastolic blood pressure was less than 90 mmHg, 5/26/16 at 2:20 p.m.	F 329		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		6/17/16

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F 441	Continued From page 34 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure that feces and contaminated Resident personal care items were not left in the communal shower room. Found in the communal shower room were; Feces, used liquid soap/shampoo, and a blue gel (unknown substance). The findings included: On 4-24-16 at 11:00 a.m. initial tour of the facility was conducted with Registered Nurse (RN) Assistant Director of Nursing (ADON) (RN) B. The communal shower room where all Residents are showered, was inspected. The following items were found: 1. Approximately 4 cups of Feces, in dime sized balls, with smears of feces in the plastic liner bag, mingled with used gloves, found in the toileting area, just inside the shower room door to the right, in an open small 2 gallon trash can. RN B stated "that is not good." 2. Liquid soap/shampoo in a plastic bottle, half empty, with the identifier of "room 5" hand written in permanent marker on it was found in the second shower room to the left. There were 2 "room 5"s in the facility, on 2 different units, and RN B could not identify which resident the soap	F 441	F 441 The dates of completion serve as my allegation of compliance. 1. The communal shower room was cleaned and checked to ensure absences of feces or contaminated resident personal care items . There were no negative outcomes to residents as a result of the findings. 2. The Administrator/Designee will be responsible for checking communal shower room on a daily basis to ensure the area is maintained within infection control compliance and free from contaminated personal resident care items or body waste. 3. The Nursing Education and Training Coordinator /Designee re-educated facility staff on "Infection Control". The inservice included but was not limited to a review of the Infection Control Program Overview policy, the importance of keeping communal areas free from contaminated personal items, handling soiled linens and proper disposal of body waste. 4. The Administrator/ Designee will inspect the communal resident shower room daily for six weeks to ensure the	

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F 441	Continued From page 35 belonged to. 3. Blue gel (unknown substance) of approximately 20 milliliters quantity, was also found on top of a sharps container, in a plastic 120 milliliters drinking cup, partially hidden under a bag of open and half empty disposable "washcloths", which RN B could not identify. RN B stated she had reported the findings to the Director of Nursing (DON), and the Administrator, later that day. On 5-26-16 at 10:00 a.m., The Infection Control Coordinator review was conducted with the person responsible for the program, Assistant Director of Nursing Registered Nurse (RN C). RN C was asked if she was aware of the infection control breach for items found in the communal shower room during tour of the facility with surveyors and RN B, and she stated "yes". She went on to say, that the Administrator and DON were aware, and had investigated the issue. RN C stated that the Maintenance director told the Administrator, the DON, and herself that they had been cleaning out drains and that is where the feces had come from. She was unable to explain why other Resident personal care items were found there. No further information was provided by the facility.	F 441	room is free from contaminated personal belongings and body waste . The Administrator will report any patterns or trends to the Continuous Quality Improvement Committee at least quarterly.	