STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVANTE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 1/24/17 through 1/26/17. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 103 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents # 1 through 18 and 22) and three closed record reviews (Residents # 19 through 21).	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. 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 assess one of 22 residents for self-administration of medications. Resident #13 was left unsupervised during a nebulizer treatment without a prior assessment to determine if the resident was safe to self-administer the medication. The findings include: Resident #13 was admitted to the facility on	F 176	**F – 176 Deficiency Corrected** (c)(7) The right to self-administer medications if the interdisciplinary team, 483.21(b)(2)(ii), has determined that this practices clinically appropriate. **1) How Corrective action will be accomplished for those found to have been effected.** Resident #13 was reviewed by the interdisciplinary team on 2/1/17 and it was determined that it is not appropriate at this time for her to self-administer medications. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** Current residents with Nebulizer treatments were audited by the Interdisciplinary Team on 2/6/17 to determine ability to self-administer medication no changes to current plan of care required.	2/24/17

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

Administrator 2/10/17

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 176	Continued From page 1 10/1/15 with a re-admission on 11/25/16. Diagnoses for Resident #13 included heart failure, Alzheimer's, anxiety, depression, pneumonia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 12/6/16 assessed Resident #13 with severely impaired cognitive skills. During the initial tour of the facility on 1/24/17 at 1:50 p.m., Resident #13 was observed seated in her wheelchair in her room. The resident had a nebulizer mask in place with the nebulizer machine running. There were no staff members in the room. Resident #13's roommate asked at this time if someone could check the resident because she thought all the medicine was gone in the mask as it had been running for "quite awhile." Resident #13's clinical record documented a physician's order dated 1/18/17 for Albuterol Sulfate nebulizer solution 0.083% to be administered via nebulizer four times per day for shortness of breath associated with COPD. The record documented no assessment regarding the resident's ability to safely self-administer any medications. There was no physician's order or care plan entries regarding self-administration of medications. On 1/25/17 at 9:30 a.m. the licensed practical nurse (LPN #1) administering medications to Resident #13 was interviewed about the resident being unsupervised with the nebulizer treatment. Concerning the resident's ability to self-administer the nebulizer medication, LPN #1 stated, "Each nurse makes the call about that [self-administration]." When asked if the resident had been assessed to self-administer medicines,	F 176	**F-176 Continued** **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-services were initiated on 1/27/17 for current licensed staff to include proper visualization of resident during nebulizer treatment and staff will remain with resident until nebulizer treatment is completed. The Unit manager or designee will randomly observe the administration of the nebulizer treatment weekly times 4 weeks then randomly thereafter reporting findings to the Director of Nursing. **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review reports weekly 4 times four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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F 176	Continued From page 2 LPN #1 stated, "No. She [Resident #13] is on hospice." LPN #1 stated she usually put the mask on the resident, started the machine and stayed "across the hall." LPN #1 stated Resident #13 was sometimes non-compliant with leaving the mask in place during the treatment. LPN #1 stated, "Sometimes she will take off the mask." On 1/25/17 at 9:35 a.m. the director of nursing (DON) was interviewed about an assessment for Resident #13 to self-administer medicines. The DON stated the nurses were supposed to be monitoring the residents during nebulizer treatments. The DON stated no prior assessment had been completed indicating Resident #13 was safe to self-administer medications. On 1/27/17 at 9:45 a.m. the DON stated Resident #13 should have been observed while receiving the nebulizer treatment. The facility's policy titled Self-Administration of Drugs (revised August 2012) stated, "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so...As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications... If the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications..." These findings were reviewed with the administrator and director of nursing during a meeting on 1/25/17 at 4:30 p.m.	F 176		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	**F – 279 Deficiency Corrected**	**2/24/17**

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F 279	Continued From page 3 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279	**F – 279 Deficiency Corrected** (d) Use. A Facility must maintain all resident assessments completed within the previous 15 months in the resident's active medical record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. **1) How Corrective action will be accomplished for those found to have been effected.** Resident #9's comprehensive care plan was updated on **1/25/17** to reflect appropriate plan of care for visual deficits. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** MDS staff completed an audit on 2/5/17 for current resident care plans that triggered for vision; where appropriate care plans were updated as necessary. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-service was completed for the MDS staff on 2/1/17 including Care Plan review, revision and implementation. Random care plan audits by MDS or Designee will be completed once a week for four weeks reporting findings to the Director of Nursing for follow-up.	

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F 279	Continued From page 4 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop comprehensive care plan for one of 22 residents, Resident # 9. Resident # 9 did not have a comprehensive care plan to include vision. Findings include: Resident # 9 was admitted to the facility on 3/5/15 with a readmission on 6/22/15 with diagnoses including Optic atrophy (degeneration of the optic nerve). The most recent MDS (minimum data set) was a	F 279	**F-279 Continued:** **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review reports of MDS findings weekly 4 times four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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F 279	Continued From page 5 quarterly assessment with an ARD (assessment reference date) of 1/10/17. Resident #9 was assessed as being moderately cognitively intact. Resident # 9's electronic record was reviewed on 1/24/17 and evidenced, via comprehensive MDS dated 4/5/16, section "V" that Resident # 9 had triggered for a care plan for vision due to weakening of the optic nerve. During a meeting conducted on 1/25/17 at 4:30 p.m. the director of nursing (DON) was asked to help locate Resident # 9's care plan regarding vision as this surveyor was unable to review this in Resident # 9's clinical record. On 1/26/17 at 8:30 a.m. the DON verbalized that Resident # 9 had triggered for a care plan to be developed for vision but was overlooked by he MDS coordinator, therefore not completed. No further information was presented prior to exit conference on 1/26/17.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 280	**F – 280 Deficiency Corrected** 483.10 (C)(2) The right to participate in the development and implementation of his or her person-centered plan of care…. **1) How Corrective action will be accomplished for those found to have been effected.** Care Plan for Resident #4 was updated on 1/25/17 to reflect the use of eye drops. Care Plan for Resident #3 was updated on 1/25/17 to correct the "Heels up cushion" to be used in the resident's "bed" not "wheel chair" Care Plan for resident #1 was updated on 1/26/17 to reflect the current plan of care for resident's Left Hand contractures.	2/24/17

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F 280	Continued From page 6 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 280	**F-280 Continued:** **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** Residents who currently have physician orders for eye drops were audited to ensure their care Plan were updated and reflected eye drop use. Residents who currently have physician orders for use of a "heels up cushion" were audited to ensure their Care Plan were updated and reflected appropriate placement and use. Current residents who have physician orders to address either right or left hand contractures were audited to ensure that their care plan reflected appropriate interventions. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-service was completed for the MDS staff on 2/1/17 including Care Plan review, revision and implementation. Audits by MDS or Designee for will be completed once a week for four weeks then randomly thereafter. Audit findings will be reported to the Director of Nursing for any needed corrective action and follow-up	

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F 280	Continued From page 7 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for three of 22 residents in the survey sample, Residents #4, #3 and #1. 1. Facility staff failed to update Resident #4's CCP for the use of eye drops, intermittent self catheterization, ambulation and call bell placement. 2. Facility staff failed to revise the CCP for	F 280	**F-280 Continued:** **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review audit reports findings weekly for four weeks and report findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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Resident #3 to include use of a foot cradle/cushion when up in a wheelchair.

3. Facility staff failed to include interventions for ROM (range of motion) to Resident #1's hand contracture.

Findings included:

1. Facility staff failed to update Resident #4's CCP for the use of eye drops, intermittent self catheterization, ambulation and call bell placement.

Resident #4 was originally admitted to the facility on 06/03/2013 and readmitted on 12/20/2016 with diagnoses including, but not limited to: Hypertension, Depression, Anxiety, Neurogenic Bladder, Urinary Retention, Polyosteoarthritis and Peripheral Vascular Disease.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 01/10/2017. Resident #4 was assessed as moderately impaired in her cognitive skills with a total cognitive score of 10 out of 15.

Resident #4's CCP was reviewed 01/25/17 at 7:30 a.m. The focus area of "Impaired vision function" included "10/12/16: Has dry eyes, drops ordered." Subsequent review of Resident #4's current physician orders, dated 01/01/17 through 01/31/17 and January 2017 MAR's (medication administration sheets) did not include any order for eye drops or any administration record of eye drops.

Included in the focus area of "Intermittent

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catheterization r/t (related to) dx (diagnosis) of Urinary retention" dated 06/14/2013 was an intervention, "Intermittent self cath per MD (physician) order..." Also under the focus area of ADL's (activities of daily living) dated 06/04/13 and revised on 05/13/16 was an intervention that stated, "...Toilet Use: resident performs self cath as needed..." The current physician orders did not include any order or instructions for self catheterization by Resident #4.

The focus area of "ADL Self Care Performance Deficit..." dated 06/04/13 and revised on 05/13/16 included these interventions: "...Ambulation: ambulates with assist of 1 (one) person..." dated 07/18/13, revised 11/14/13 and "...(Name) Resident #4 prefers to have call bell hanging on the privacy curtain..." dated 04/08/16. During the survey conducted 01/24/17 through 01/26/17 Resident #4 was never observed out of the bed or ambulating. Resident #4 was observed in bed on 01/24/17 at 3:10 p.m., 01/25/17 at 7:30 a.m. and 01/26/17 at 8:30 a.m. Resident #4's call bell was attached to her bed sheet by her pillow during all three observations.

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 01/25/17 at approximately 4:30 p.m. The DON was interviewed regarding who is responsible for updating care plans. The DON stated, "The MDS nurses."

No further information was received by the survey team prior to the exit conference on 01/26/17.

2. The facility staff failed to review and revise the CCP (comprehensive care plan) for Resident # 3

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regarding the use of a heels up cushion.

Resident # 3 was admitted to the facility on 01/14/13, with the most current readmission on 12/05/16. Diagnosis for Resident # 3 included, but were not limited to: anemia, DM (diabetes mellitus), arthritis, and renal insufficiency.

The most current full MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 10/11/16. The resident was assessed as having a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills.

The resident was also assessed at being at risk for pressure and triggered in the CAAS (care area assessment summary) for pressure.

Resident # 3 was observed on 01/24/17 at approximately 3:30 p.m. in her room. The resident was sitting in her w/c (wheelchair), with a cushion in the seat. The resident had shoes on with her feet resting on the floor.

The resident was observed on 01/25/17 at 9:30 a.m., lying flat in her bed, fully dressed, including shoes. The resident stated that staff were about to get her up with the lift.

Two staff members came into the room, used the lift and got Resident # 3 up to her w/c. The resident was again observed with her feet flat on the floor.

Resident # 3's clinical record was reviewed.

The resident's current CCP documented, "...Heels up cushion in w/c to decrease risk of

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pressure...[date initiated: 11/14/16]"

On 01/15/17 at approximately 10:30 a.m., the corporate DON (director of nursing) was asked what the heels up cushion was for. The DON explained that it was to keep the heels off of the floor. The DON was informed of the above observations for Resident # 3. The DON stated that she would look in to the information.

At approximately 2:30 p.m., the DON stated that the information in the CCP was incorrect and was meant for when the resident was in bed, not in the chair. The DON stated that the MDS department updates the care plans and that was not taken out.

No further information or documentation was provided prior to the exit conference on 01/16/17 at 12:00 p.m.

3. For Resident #1, the facility staff failed to update care plan to include any new interventions for contractures and range of motion therapy since 2013.

Resident # 1 was re-admitted to the facility on 7/15/2013. Diagnoses for Resident # 1 included but are not limited to cerebrovascular disease (history of a stroke), contracture unspecified hand (left), hemiplegia (one side weakness), pain, osteoarthritis, depression, and unspecified psychosis not due to a substance or known physiological condition. Resident # 1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/3/17 coded Resident # 1 with inattention and disorganized

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thinking with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident # 1 requiring extensive assistance and total dependence, on staff for Activities of Daily Living (bed mobility, dressing, and hygiene/bathing) care.

Resident # 1 was observed on 1/25/17 at approximately 9:05 a.m. Resident #1 was observed in bed without assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against and into the contracted hand. Resident #1 was observed with LPN (Licensed Practical Nurse) #4 on 1/25/17 at approximately 11:00 a.m. Again, the resident was observed in bed without assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against the contracted hand.

On 1/24/17 and 1/25/17, Resident #1's clinical record was reviewed. The reviewed showed no current physician's orders pertaining to left hand contracture. Review of the Treatment Administration Record showed no current treatments for Resident #1's contracted left hand. The most current Care Plan presented by the facility staff was reviewed and included the following:

Focus: Impaired mobility due to contractures of left hand, bilateral knees and ankle, dx [diagnosis] of hemiparesis. Date initiated 9/15/2011, Created on 9/15/2011, Revision on 1/16/2017 by MDS Coordinator.

Goal: Maintain highest level of function and prevent further degree of contractures by the end of the observation period. Date initiated

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9/15/2011, Created on 9/15/2011, Revision on 1/16/2017 by MDS Coordinator, Target date: 4/12/2017.

Interventions:
Active and passive range of motion of affected extremities PRN [as needed]. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator.

Administer pain medication if range of motion is painful prior to starting program. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator.

Encourage active participation when possible and praise all efforts. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator.

Encourage [Resident #1] to do as much as possible for himself as much as possible during care to enhance joint mobility. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator.

Explore possible use of assistive devices to aid mobility. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator.

On 1/26/17 facility staff (Administrative-Acting Director of Nursing) presented the following Care Plan regarding Resident #1's Behaviors to address observations made by surveyor and LPN #4 (Resident #1 was observed in bed without

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assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against and into the contracted hand):

Focus: [Resident #1] has behaviors of yelling out for assistance, refusing care at times, and being physically abusive to staff at times, 8/24/16 refuses bathing. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, Revision on 8/24/2016 [nothing new added] by MDS Coordinator.

Goal: [Resident #1] will continue to show signs of improvements and have all his needs met at this facility.

Interventions included but not limited to:
Explain to [Resident #1] what you are about to do prior to doing it to assist him. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, Revision on 10/21/2012 [nothing new added] by MDS Coordinator.

Offer services when refused in about 10-15 minutes later. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, and no revision date with any new interventions.

Another focus on the most current Care Plan presented by the facility staff included assistance with ADL care.

Focus: [Resident #1] has an ADL care deficit r/t [related to] dx [diagnosis] of CVA [stroke] with left sided hemiparesis [weakness]. [Resident #1] requires extensive assistance to complete ADL care.

Interventions included but not limited to :

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Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date initiated 9/14/2011, Created on 9/14/2011 by MDS Coordinator, and no revision date with any new interventions.

Bathing: Provide sponge bath on days when a full bath or shower is not given 1/16/17 [Resident #1] frequently refuses to take a shower. Date initiated 9/14/2011 Created on 9/15/2011, Revision on 1/16/2017 [nothing new added since readmission 7/15/2013 until 1/16/2017] by MDS Coordinator.

The ADL task sheets were reviewed for January 2017. The ADL tasks for January 2017 included but were not limited to: Under the title "Personal Hygiene": Gentle ROM [Range of Motion] to left upper extremity and left hand/wrist daily as tolerated. Apply left carrot splint on at all times except for bathing as tolerated. These tasks were to be performed and checked Q [every] shift.

On 1/26/17 a nursing note was presented by the facility Interim DON dated 10/02/2013 at 6:28 p.m. The note read, that Resident #1 had been refusing Restorative Nursing Program (RNP) care and had been removing splint after application by restorative CNAs. The note stated that Resident #1 was spoken to on this date regarding discontinuation of RNP due to refusals, and reads, "he [Resident #1] is in agreement with this. Will refer to floor CNA for PROM [Passive Range of Motion] and application of splint as [Resident #1] will tolerate." According to a Medical Dictionary, Passive Range of Motion involves someone else moving the joint for you."

Occupational Therapy notes were presented by the Interim DON on 1/26/17. An OT Daily

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Treatment Note dated 11/5/2014 read: "Pt's [Patient's] L [left] hand is contracted and he uses a carrot for proper splinting of L hand." An OT Evaluation and Plan of Treatment dated 2/4/2015 identified the following risk factors: "Due to documented physical impairments and associated functional deficits, the patient [Resident #1] is at risk for future decline in function, falls, limited out-of-bed activity and contractures." The OT therapy Progress Report dated 11/2/2014 outlined the onset date of diagnosis (effects of Stroke, muscle weakness) on 10/30/2011 and 3/12/2012 with Treatment (feeding difficulties and lack of coordination) onset date of 11/5/2014. The OT Evaluation and Plan of Treatment dated 1/26/2017 [based on survey findings] noted onset date of diagnosis of contracture and other cerebrovascular disease and treatment for contracture on 1/26/2017.

The OT Assessment dated 1/26/2017 read: "Current value changed from 'Patient presents with pathology consistent with diagnosis of prior CVA with L hand contracture. Patient seen this date with focus on assessment of ROM/nail length/skin integrity." The note continued to report, "Patient subjectively reported pain in his L hand. Therapist requested to see his hand and...explained that she wanted to assess his ROM both passively and actively, with patient giving hand to therapist. Upon very gentle ROM and holding his hand, he screamed in pain and became physically aggressive and yelled, 'Just leave it alone.'" The note also documented that patient was shown the carrot orthosis and refused to allow therapist to place it. The conclusion by the therapist was documented and read, "Skilled services not indicated at this time secondary to patient refusing." Nursing was notified regarding

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patient's subjective high pain levels in left hand.

A review of clinical nursing notes from 11/01/16 through 1/26/17 was conducted on 1/26/17.

On 11/06/2016 a note read, "[Resident #1]...yelling out constantly complained of pain and medicated without results...redirection unsuccessful refused ADL care..."

On 12/24/16 a weekly summary noted: [Resident #1] to be "cooperative with care most of the times, becomes agitated periodically." No mention of PROM or nail care refusal in Clinical Nursing Notes.

On 1/25/17 at approximately 9:05 a.m. Resident #1 was interviewed. Resident #1 stated, "I have arthritis pain in my left hand...the doctor down there in Florida had it better, the doctor had it opened." Resident #1 added, "I try to help myself because I have no therapy and yes my nails are going into my skin but I don't ask them [facility staff] to help...they [facility staff] don't do nothing, no cream and its cold sometimes."

On 1/25/17 at approximately 10:55 a.m. LPN #4 (consistently works with resident) and surveyor interviewed Resident #1. LPN #4 stated, "Yes, his hand is very contracted. Usually he has a carrot or a wash cloth so his nails don't go into his hands." LPN #4 also stated, "The carrot is suppose to be in there [Resident #1's contracted hand] all the time. Neither Resident #1 nor LPN #4 could locate the carrot. LPN #4 continued to say, "Yes, his nails need to be cut, they [his nails] are pressing into his hand but no marks." LPN #4 gently observed resident's hand and opened it to see no marks. Resident #1 helped LPN #4 place

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a washcloth in the contracted hand. Resident #1 yelled in pain initially but when he helped LPN #4 open each finger the wash cloth was able to go into his contracted hand. Resident #1 was cooperative and willing to work with LPN #4. LPN #4 added, "I would use both the carrot and the washcloth to help protect his hand."

On 1/26/17 at 9:13 a.m. an Occupational Therapist was interviewed. The OT stated, "He was evaluated this morning at 7:00 a.m. because nursing was concerned about his hand." The OT explained that Resident #1 complained of a lot of pain and refused ROM and refused the carrot and became aggressive. The OT stated, "I notified nursing of the pain and the refusal, I feel he has behaviors to not allow anything so I handed it over to nursing."

On 1/26/17 at approximately 9:30, CNA #2 (works consistently with Resident #1 on the day shift) was interviewed. CNA #2 stated, "He won't let you do a lot, if he lets me, I put the carrot in his hand and wash it out." CNA #2 explains that she tries daily and if the resident refuses she will document this refusal on the ADL log. CNA #2 stated, "I have not had success with nails...for quite a while, he doesn't like you to touch his hands because it hurts." CNA also explained that she will let the nursing staff know if he is in pain after ADLs. CNA #2 did not know when Resident #1 receives pain medication. CNA #2 also stated, "I don't know if he is in restorative therapy...ask therapy they would know...and no I don't do range of motion with him."

On 1/26/17 at approximately 9: 35 a.m. LPN #1 (On duty and was told by OT of the Resident#1's pain) was interviewed. LPN #1 stated, "Yes, it was

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reported to me and I put a note in regarding he OT evaluation." LPN #1 does not work with Resident #1 often. LPN #1 said she went in to talk with the resident around 7:45 a.m. and he did not want anything for pain. LPN #1 said she would try 2 to 3 times to assist with pain if he refused. LPN #1 said, "I spoke with family a few weeks ago and they feel he may be giving up." LPN #1 stated, "From here I would look at quality of life for him [Resident #1], talk with family, keep him comfortable maybe talk with the doctor about liquid morphine or ativan because liquid is easy to get into people to keep comfortable." LPN #1 said, "Pain is impacting his life so I am going to communicate with the doctor or NP to explore other avenues, like we could schedule medications at 7:30 a.m. prior to ADLs, we could use Norco for break through pain prior to ADLs, or use the Aspercream prior to nail care and placing the carrot, and we could increase the MCGs (Micrograms) on the Fentanyl patch."

A final interview was conducted on 1/26/2017 at 9:45 a.m. with Resident #1. Resident #1 was observed with nails cut and carrot in left hand. Resident #1 said, "Its ok in my hand" [referring to the carrot] and "I want that done [referring to nails cut regularly]." Resident also stated, " I want my nails cut and I want the doctor to tell me its ok-I don't trust them [facility staff]." He added, "It [his left hand] is really painful and I talk about it but they don't listen."

On 1/26/16 at approximately 10:00 a.m., the DON was interviewed and stated, "LPN #4 cut the nails for Resident #1 and he was fine if he did not watch the nails while cutting but when he looked he would get nervous." Also the DON stated several times that Resident #1 has behaviors and

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F 280	Continued From page 20 refuses care. The care plan did not reflect any new interventions or attempts or approaches to Resident #1's left hand contracture/ ROM since. Only one Social Work Resident Progress Review was presented regarding Resident #1's behaviors dated 1/5/2016 and when asked for an updated review, the DON stated, "We have none." No policies were presented regarding updated care plans. The facility administration was informed of the findings during a briefing on 1/26/17 at approximately 11:00 a.m.. The facility did not present any further information about the findings.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (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, clinical record review and facility document review, the facility staff failed to follow professional standards of nursing practice for three of 22 residents in the survey sample, Resident # 14, # 17 and # 18. 1. The facility staff failed to follow manufacturer's instructions for the administration use of single dose diazepam syringes for Resident # 14; the facility staff accessed the single dose units multiple times putting the medication at risk for	F 281	**F – 281 Deficiency Corrected** (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. **1) How Corrective action will be accomplished for those found to have been effected.** Resident #14's Medication regimen was reviewed & updated by the attending physician on 1/25/17. Upon further Physician review the medication was discontinued. Resident #17's and Resident #18's nurses' were given 1on1 re- education on the proper medication administration on 2/2/17.	2/24/17

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F 281	Continued From page 21 contamination and the resident at risk of infection. 2. During observation of the Medication Pass and Pour, medications for Resident # 18 were left on the resident's bedside table. The resident took the medications without supervision and without being observed by the administering nurse. 3. During the observation of the Medication Pass and Pour, the administering nurse turned her back to Resident # 17, leaving an aerosol spray (Fluticasone Propionate) on the bedside table within reach of the resident. Findings include: 1. The facility staff failed to follow manufacturer's instructions for the administration use of single dose diazepam syringes for Resident # 14; the facility staff accessed the single dose units multiple times putting the medication at risk for contamination and the resident at risk of infection. Resident # 14 was admitted to the facility on 06/14/14, with the most current readmission on 08/15/15. Diagnoses for Resident # 14 included, but were not limited to: dementia, anxiety disorder, psychotic disorder, schizophrenia, and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment dated 11/08/16, which assessed the resident as having a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills. On 01/25/17 the facilities medication carts on A	F 281	**F-281 Continued:** **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** The facility has determined that all current residents have the potential to be affected. In-services initiated on 2/7/17 for current licensed nursing staff to included proper administration of single dose vial medications as per manufacture guidelines and observation of all medications until consumption is completed, this will be included in Orientation of new licensed staff.. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** The Unit Manager or designee will audit during a weekly medication pass observation weekly times 4 weeks; to determine compliance with adherence to proper medication administration protocol weekly times 4 weeks reporting findings to the Director of Nursing for appropriate follow-up. **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review reports weekly 4 times four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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wing were observed at approximately 11:15 a.m.

RN (Registered Nurse) # 2 was asked to explain the process for narcotic administration. RN # 2 stated that first she looks at the computer to ensure the order, then retrieves the 'sign out' narcotic log book from the side of the medication cart and turns to the resident's page for that medication, verifies and then opens the narcotic drawer and retrieves the medication, sign's it out in the book and then administers it.

RN # 2 was asked to give a demonstration. RN # 2 opened the narcotic book and turned to Resident # 14's page.

Resident # 14's page listed the drug as "diazepam [a schedule IV/4 medication] with lure lock 5 mg/1 ml [milligrams/milliliter] DISP SYRIN M GIVE (0.2 ML INTRAMUSCULAR NOW * THEN GIVE (0.2 ML) EVERY 30 MIN AS NEEDED FOR 3 DAYS FOR SEIZURES" The page documented the date received, 11/14/16 and the quantity (received), 5 pens/syringes-10 mg in each pen/syringe.

RN # 2 opened the narcotic drawer and pulled out a Ziploc bag. The RN stated that this is the only pen left in this bag, she started out with 5 and this is what is left of this order. Inside the bag was one manufactured, glass pen/syringe in a plastic tubular sleeve. The pen/syringe was removed and observed as a 10 mg/ 2 ml pen/syringe. The syringe had "graduation marks" (units of measure/scale markings listed in cubic centimeters of milliliters), which are marks to indicate the amount left in the syringe. This pen/syringe was observed with 1.5 ml/7.5 mg remaining (meaning that .5 ml/2.5 mg had been

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administered to the resident). The nurse was then asked how they (staff nurses) administer this medication and was asked if the nurses use a standard syringe to draw the medication out of the glass syringe or do they put a needle on the end of the glass syringe and administer that way. The RN stated, "Well it's IM [intramuscular], I really don't know I have never administered it [from the glass syringe] before."

The glass syringe was observed again and did not have any information on the actual package to indicate that this was a multi dose syringe. The RN was asked if they (staff nurses) just use what is needed and then store the unused medication back in the cart for the next dose. The RN stated, "It looks that way." The RN was asked to provide a manufacturer's package insert for this medication. The RN stated that she would notify pharmacy to have the information faxed.

At approximately 12:15 p.m., the facility pharmacist and the corporate DON (director of nursing) were asked to observe the above findings and to clarify if the glass syringe was to be used as a multi dose vial. RN # 2 removed the medication from the locked narcotic drawer and handed the medication to the pharmacist. The pharmacist stated, "If it has a needle then that would be a single dose." The glass syringe was then taken out of the plastic tube and the top removed, there was no needle.

The pharmacist then stated that the package should actually say if it is a multi dose syringe and went on to say, "It does not." The corporate RN stated that the rest of the medication in that syringe should have been wasted when the last

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dose was administered on 01/16/17.

At approximately 12:30 p.m., the package insert for the above medication was presented. The package insert information documented, "...How Supplied: Carpuject Sterile Cartridge Unit with Luer Lock...Concentration 10 mg/2 ml (5 mg/1 ml)...Carpuject [TM/trademark], Single-dose cartridge with Luer Lock for the Carpuject Syringe System..."

Upon further review of Resident # 14's narcotic sheet for diazepam, it was found that the narcotic count of this medication was off by 0.3 ml between 12/29/16 and 01/06/17, there was no record of administration or of the medication being wasted.

At approximately 3:30 p.m., the above information and concerns were discussed with the administrator and corporate DON. Both agreed that the medication syringe should only have been accessed one time and then any remaining medication should have been wasted, since these were single dose medication units. No explanation was provided regarding the medication count/reconciliation of the unaccounted for 0.3 ml of the diazepam for Resident # 14.

At approximately 4:15 p.m., the corporate DON stated that the facility did not have specific policy, as requested above but did have a paid subscription to a nursing resource that they (the facility) uses for reference and presented an insert titled, "Injectable Medication Administration", was presented and documented: "...The Association of Professionals in Infection and Control and Epidemiology guideline and the

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F 281	Continued From page 25 World Health Organization recommend using single-use or single-dose vials whenever possible. A multidose vial poses a risk of transmission by inappropriate handling...Always follow manufacturer's instructions for storage and use of medication vials and label multidose vials with the date immediately upon opening. To reduce the risk of contamination, most facilities dispense parenteral medications in single-dose vials...you should only use multidose vials only if there's no alternative...You should use vials labeled by the manufacturer as "single dose" or "single use" for a single patient only. These medications lack antimicrobial preservatives and can become contaminated and serve a source of infection if used inappropriately...Record the drugs administered, injection site, and time of administration..." No further information or documentation was provided prior to the exit conference on 01/26/17 at 12:00 p.m. 2. Resident #18 was admitted to the facility on 6/30/17. Diagnoses for Resident #18 included but are not limited to urinary retention, infection, depression, hypertension, gastroesophageal reflux disease, and overactive bladder. Resident #18's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/3/17 coded Resident #16 as modified independent and no cognitive impairment. In addition, the Minimum Data Set coded Resident #18 requiring supervision for Activities of Daily Living care.	F 281		

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On 1/25/17 at approximately 8:08 a.m. during Medication Administration Observation LPN #2 turned her back and washed her hands for at least 3 minutes leaving a cup with 7 pills on the bedside table and Resident #18 took the 7 pills without supervision. LPN #2 did not observe the medication administration.

On 1/25/17, Resident #18's clinical record was reviewed. The reviewed showed physician orders dated 1/1/2017 through 1/25/2017. The orders read, Resident #18 was to get the following 7 pills:

1. Flomax Capsule 0.4 MG (milligrams), Give 1 capsule by mouth one time a day for urinary retention.
2. Doxycycline Hyclate Tablet 100 MG, Give 1 tablet by mouth one time only for infection for 1 day and give 1 tablet by mouth two times a day for infection for 10 days.
3. Duloxetine HCL (hydrochloride) Delayed Release Particles 30 MG, Give 1 capsule by mouth one time a day for depression MD/NP (doctor/nurse practitioner) aware of patient taking 60 MG in the evenings.
4. Lisinopril Tablet 20 MG, Give 20 MG by mouth one time a day for hypertension.
5. Omeprazole Tablet Delayed Release 20 MG, Give 20 MG by mouth two times a day for GERD.
6. Oxybutynin Chloride Tablet Extended Release 24 hour 5 MG, Give 1 tablet by mouth one time a day for overactive bladder, do not crush.
7. Saccharomyces Boulardil Capsule 250 MG, Give 1 capsule by mouth two times a day for probiotic for 21 days.

On 1/25/17 at approximately 3:15 p.m. the MDS Coordinator (RN #1) was interview as she was

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the DON (Director of Nursing) at the facility prior to the current interim DON. RN #1 stated, "Residents are to be kept in sight of nursing" and "nursing should be watching while medications are in reach of resident." RN #1 added, "No one is currently care planned to self administer medications."

On 1/26/17 at approximately 9:20 a.m. LPN#2 (Licensed Practical Nurse) was interviewed. LPN #2 agreed that she had turned her back on Resident #18 to wash her hands while Resident #18 took 7 pills placed on the bedside table near the resident. LPN #2 said, "I usually watch the residents when giving medication." When asked why do you watch residents while taking medications LPN #2 answered, "To make sure all [pills] are taken and they [residents] don't drop some [pills] and they [residents] don't choke, and [residents] don't miss any [pills]."

On 1/26/17 at approximately 9:25 a.m. the Interim DON stated that the expectation was for nursing staff to watch residents take medications.

3. Resident #17 was admitted to the facility on 2/30/17. Diagnoses for Resident #17 included but are not limited to allergic rhinitis, allergies, and manic bipolar. Resident #17's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/3/17 coded Resident #17 as modified independent and no cognitive impairment. In addition, the Minimum Data Set coded Resident #17 requiring limited to extensive assistance for Activities of Daily Living care.

On 1/25/17 at approximately 8:30 a.m. during

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Medication Administration Observation LPN #1 turned her back and stood at the medication cart at the door for at least 5 minutes leaving medication (Fluticasone Propionate Aerosol Spray) at the bedside table within reach of Resident #17.

On 1/25/17, Resident #17's clinical record was reviewed. The reviewed showed physician orders dated 1/1/2017 through 1/25/2017. The order read, Resident #17 was to get: Fluticasone Propionate HFA Aerosol, 1 spray alternating nostrils two times a day for Allergic Rhinitis (hay fever-inflammation of the nose).

On 1/25/17 at approximately 8:45 a.m. LPN #1 was interviewed. LPN #1 stated, "Yes I did turn my back on the resident and left the spray at bed side." LPN #1 added, "I should not have done that."

On 1/25/17 at approximately 3:15 p.m. the MDS Coordinator (RN #1) was interview as she was the DON (Director of Nursing) at the facility prior to the current interim DON. RN #1 stated, "Residents are to be kept in sight of nursing" and "nursing should be watching while medications are in reach of resident." RN #1 added, "No one is currently care planned to self administer medications."

On 1/26/17 at approximately 9:25 a.m. the Interim DON stated that the expectation was for nursing staff to have eyes on the resident at all times and never leave medication at the bed side.

The Lippincott Manual of Nursing Practice 10th edition states on page 16 concerning standards of nursing care, " Legal claims most commonly

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F 281	Continued From page 29 made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered ... " Page 17 of this reference states common departures from standards of care include, " Failure to monitor or observe a patient ' s clinical status ... Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately ... Failure to observe a medication ' s action or adverse effect ... Failure to adhere to facility policy or procedural guidelines ... " (1) (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. The facility administration was informed of the findings during a briefing on 1/26/17 at approximately 11:00 a.m. The facility did not present any further information about the findings.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309	**F – 309 Deficiency Corrected** 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.	**2/24/17**

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F 309	Continued From page 30 comprehensive assessment and plan of care. 483.25 (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, and the residents' goals and preferences. (l) 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, family interview, staff interview and clinical record review, the facility staff failed to assess and promptly treat one of 22 residents in the survey sample, Resident # 6. The facility staff failed to perform a skin assessment for Resident # 6, which resulted in a delay in treatment. Findings include: Resident # 6 was admitted originally to the facility on 05/04/16. Diagnoses for Resident # 6 included, but were not limited to: history of DVT (deep vein thrombosis), DM (diabetes mellitus), Alzheimer's dementia, anxiety disorder and arthritis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/21/16, which assessed the	F 309	**F-309 Continued:** **1) How Corrective action will be accomplished for those found to have been effected.** Resident # 6's skin assessment was completed on 1/26/17, no further interventions were required. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** An audit of current residents was completed on 2/6/17. The audit validated compliance with weekly skin assessment protocols. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-services for current licensed staff was initiated on 2/7/17 to include proper and timely completion of a weekly skin assessment and facility protocol compliance. The Unit Manager or designee will monitor skin assessment protocol compliance 5 times a week for four weeks with reporting of the findings to the Director of Nursing for appropriate follow-up.	

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F 309	Continued From page 31 resident as having long and short term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for all ADL's (activities of daily living) including transfers, dressing and hygiene. On 01/25/17 at approximately 2:15 p.m., Resident # 6's husband requested an interview. During this interview the husband brought up concerns regarding Resident # 6, specifically regarding the resident's left great toe. The resident's husband stated that the resident's toe had become red and sore and that he had reported it approximately 3 weeks ago to RN (Registered Nurse) # 3. The husband then went on to say that he thought the this issue had been communicated, until he came in to on Sunday January 22, 2017 and the toe actually looked worse. The husband stated that he reported it again. The husband stated that his wife was finally seen for this on Monday, January 23 (2017). The husband stated that the NP (nurse practitioner) had come to see it and that he (the husband) reported to the NP that this had actually been reported several weeks ago and was very upset that it was just being seen. At approximately 2:30 p.m., the husband removed the resident's sock to expose the resident's toes. The resident's toe was very red, slightly swollen, with a small dark area at the top of the toe, close to the cuticle. The resident yelled out, "Ouch" and jerked her foot back. The husband again stated displeasure at the fact it had been several week and the information was not acted upon. The husband stated that the resident received two baths per week, as well and	F 309	**F-309 Continued:** **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review monitoring audit reports weekly for four weeks, reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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it should have been identified.

Resident # 6's clinical record was reviewed and documented that the resident was started on antibiotics on 01/24/17 for cellulitis of the left toe for 10 days.

Resident # 6's weekly skin assessment sheets were then reviewed.

A weekly skin assessment dated 01/12/17 and timed for 2:19 p.m. documented no new areas.

A weekly skin assessment completed by RN # 3, dated 01/12/17 and timed 11:11 p.m. documented no new skin areas.

A skin assessment for the following week (01/19/17) was not completed.

The wound care nurse was interviewed on 01/26/17 at approximately 9:00 a.m. regarding Resident # 6's toe/foot. The wound care nurse stated that it was reported to her on Monday and that she does not complete weekly skin assessment sheets, the floor nurses do that. The wound care nurse stated that she had looked at the toe on Monday and that the NP did not order a treatment, only antibiotics. The wound care nurse was asked, why a skin assessment sheet was not completed at that time. The wound care nurse stated, "I was looking at it every day." The wound care nurse was asked why that information would not be documented to let everyone know there was an issue with the resident's toe and to document the progress of the toe. The wound care nurse stated, "I should have."

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F 309	Continued From page 33 The wound care nurse was asked for a policy on wounds. A policy on "Prevention of Pressure Ulcers" was presented and reviewed. The policy documented, "...weekly skin assessment will be performed by nursing staff and any issues noted will be addressed by a Physician or designee as required..." The administrator and corporate DON (director of nursing) were made aware of concerns regarding Resident # 6's skin assessment not being completed as ordered, which resulted in delayed treatment. No further information or documentation was presented prior to the exit conference on 01/26/17 at 12:00 noon.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 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 to provide nail care for one of 22 residents. (Resident # 1). The facility staff failed to provide nail care from prior to 1/11/2017 to 1/26/2017. The findings included:	F 312	**F – 312 Deficiency Corrected** (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **1) How Corrective action will be accomplished for those found to have been effected.** Resident # 1's fingernails were trimmed on 1/26/17 by facility nurse. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** A complete audit of current resident fingernails was completed on 2/6/17 and where indicated resident nails were trimmed appropriately.	2/24/17

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F 312	Continued From page 34 Resident # 1 was re-admitted to the facility on 7/15/2013. Diagnoses for Resident # 1 included but are not limited to cerebrovascular disease (history of a stroke), contracture unspecified hand (left), hemiplegia (one side weakness), pain, osteoarthritis, depression, and unspecified psychosis not due to a substance or known physiological condition. Resident # 1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/3/17 coded Resident # 1 with inattention and disorganized thinking with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident # 1 requiring extensive assistance and total dependence, on staff for Activities of Daily Living (bed mobility, dressing, and hygiene/bathing) care. Resident # 1 was observed on 1/25/17 at approximately 9:05 a.m. Resident #1 was observed in bed without assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against and into the contracted hand. Resident #1 was observed by surveyor with LPN (Licensed Practical Nurse) #4 on 1/25/17 at approximately 11:00 a.m. Again, the resident was observed in bed without assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against the contracted hand. On 1/26/2017 at 9:45 a.m. Resident #1 was observed with nails cut and carrot in left hand. On 1/24/17 and 1/25/17, Resident #1's clinical record was reviewed. The reviewed showed no current physician's orders pertaining to nail care. Review of the Treatment Administration Record showed no current treatments for Resident #1's nail care. The most current Care Plan presented	F 312	**F-312 Continued** **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-service was initiated on 2/7/17 with current nursing staff to include proper nail care during ADL's and that when indicated, the CNA will refer residents to the nurse for appropriate intervention.. The Unit Manager or designee will audit 5 residents for compliance with nail care protocols, no less than 5 days a week for 4 weeks of nail observations. Audit compliance findings will be reported to the Director of Nursing for appropriate review and where necessary, follow-up. **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review audit reports weekly for four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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by the facility staff was reviewed and included the following about nail care:

Focus: [Resident #1] has an ADL care deficit r/t [related to] dx [diagnosis] of CVA [stroke] with left sided hemiparesis [weakness]. [Resident #1] requires extensive assistance to complete ADL care.

Interventions included but not limited to :
Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date initiated 9/14/2011, Created on 9/14/2011 by MDS Coordinator, and no revision date with any new interventions.

Bathing: Provide sponge bath on days when a full bath or shower is not given 1/16/17 [Resident #1] frequently refuses to take a shower. Date initiated 9/14/2011 Created on 9/15/2011, Revision on 1/16/2017 [nothing new added since readmission 7/15/2013 until 1/16/2017] by MDS Coordinator.

Focus: [Resident #1] has behaviors of yelling out for assistance, refusing care at times, and being physically abusive to staff at times, 8/24/16 refuses bathing. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, Revision on 8/24/2016 [nothing new added] by MDS Coordinator.

Goal: [Resident #1] will continue to show signs of improvements and have all his needs met at this facility.

Interventions included but not limited to:
Explain to [Resident #1] what you are about to do prior to doing it to assist him. Date initiated 9/13/2012, Created on 9/13/2012 by Social

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Worker, Revision on 10/21/2012 [nothing new added] by MDS Coordinator.

Offer services when refused in about 10-15 minutes later. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, and no revision date with any new interventions.

The Interim DON presented shower lists to show Resident #1's refusal for nail care. It remained unknown [no documentation] as to when the last time Resident #1 had nails cut. The Shower List from 1/11/17 documented that Resident #1 refused nail care and shampoo. No other documentation followed and no other attempts were made to cut Resident #1's nails. The Shower List from 1/14/17 documented that Resident #1 had refused nail care. No other documentation followed and no other attempts were made to cut Resident #1's nails. The Shower List dated 1/18/17 documented that Resident #1 refused nail care and a shave. No other documentation followed and no other attempt was made to provide nail care.

An OT Assessment dated 1/26/2017 read: "Current value changed from 'Patient presents with pathology consistent with diagnosis of prior CVA with L hand contracture. Patient seen this date with focus on assessment of ROM/nail length/skin integrity." The note continued to report, "Patient subjectively reported pain in his L hand.

On 1/25/17 at approximately 9:05 a.m. Resident #1 was interviewed. Resident #1 stated, "I have arthritis pain in my left hand...the doctor down there in Florida had it better, the doctor had it opened." Resident #1 added, "I try to help myself

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because I have no therapy and yes my nails are going into my skin but I don't ask them [facility staff] to help...they [facility staff]don't do nothing, no cream and its cold sometimes."

On 1/25/17 at approximately 10:55 a.m. LPN #4 (consistently works with resident) and surveyor interviewed Resident #1. LPN #4 stated, "Yes, his hand is very contracted. Usually he has a carrot or a wash cloth so his nails don't go into his hands." LPN #4 also stated, "The carrot is suppose to be in there [Resident #1's contracted hand] all the time. Neither Resident #1 nor LPN #4 could locate the carrot. LPN #4 continued to say, "Yes, his nails need to be cut, they [his nails] are pressing into his hand but no marks." LPN #4 gentle observed resident's hand and opened it to see no marks. Resident #1 helped LPN #4 place a washcloth in the contracted hand. Resident #1 yelled in pain initially but when he helped LPN #4 open each finger the wash cloth was able to go into his contracted hand. Resident #1 was cooperative and willing to work with LPN #4. LPN #4 added, "I would use both the carrot and the washcloth to help protect his hand."

On 1/26/17 at approximately 9:30, CNA #2 (works consistently with Resident #1 on the day shift) was interviewed. CNA #2 stated, "He won't let you do a lot, if he lets me, I put the carrot in his hand and wash it out." CNA #2 explains that she tries daily and if the resident refuses she will document this refusal on the ADL log. CNA #2 stated, "I have not had success with nails...for quite a while, he doesn't like you to touch his hands because it hurts." CNA also explained that she will let the nursing staff know if he is in pain after ADLs.

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F 312	Continued From page 38 On 1/26/2017 at 9:45 a.m. Resident #1 was interviewed. Resident #1 said, "Its ok in my hand" [referring to the carrot] and "I want that done [referring to nails cut regularly]." Resident also stated, " I want my nails cut and I want the doctor to tell me its ok-I don't trust them [facility staff]." He added, "It [his left hand] is really painful and I talk about it but they don't listen." On 1/26/16 at approximately 10:00 a.m., the DON was interviewed and stated, "LPN #4 cut the nails for Resident #1 [this morning] and he was fine if he did not watch the nails while cutting but when he looked he would get nervous." Also the DON stated several times that Resident #1 has behaviors and refuses care. Administrative staff and DON agreed that Resident's nails were long and in need of cutting. No policies were presented by the facility staff concerning nail care but reference was made to follow the plan of care. The facility administration was informed of the findings during a briefing on 1/26/17 at approximately 11:00 a.m. The facility did not present any further information about the findings.	F 312		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives	F 318	**F – 318 Deficiency Corrected** (c) Mobility (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion…	**2/24/17**

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F 318	Continued From page 39 appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 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 to evaluate and provide appropriate ROM (range of motion) services and treatment for 1 of 22 residents (Resident # 1). The facility staff failed to evaluate Resident #1's contracted left hand from 2013 to 1/26/17, and failed to provide treatment and services to assist with contracture. The findings included: Resident # 1 was re-admitted to the facility on 7/15/2013. Diagnoses for Resident # 1 included but are not limited to cerebrovascular disease (history of a stroke), contracture unspecified hand (left), hemiplegia (one side weakness), pain, osteoarthritis, depression, and unspecified psychosis not due to a substance or known physiological condition. Resident # 1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/3/17 coded Resident # 1 with inattention and disorganized thinking with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident # 1 requiring extensive assistance and total dependence, on staff for Activities of Daily Living (bed mobility, dressing, and hygiene/bathing) care. Resident # 1 was observed on 1/25/17 at approximately 9:05 a.m. Resident #1 was observed in bed without assistive device (a carrot	F 318	**F-318 Continued:** **1) How Corrective action will be accomplished for those found to have been effected.** Occupational Therapists of the Therapy Department, attempted times 2 on 1/26/17 to evaluate resident #1's left hand, but resident #1 refused both re-evaluations. On 2/9/17 another attempt was made by the Therapy Department staff, but again was refused by the resident. Resident #1 was educated by appropriate clinical staff regarding ROM therapeutic treatment(s) and is aware of the benefits and risks associated with non-acceptance of treatment. Resident #1's Care Plan was updated to reflect his refusal of necessary and offered therapeutic care to address clinically identified needs. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** A complete audit of current residents with hand contractures was completed by the clinical team on 2/6/17. No other residents were identified as having unmet clinical needs.	

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F 318	Continued From page 40 or washcloth) in contracted left hand with very long finger nails pressing against and into the contracted hand. Resident #1 was observed by surveyor with LPN (Licensed Practical Nurse) #4 on 1/25/17 at approximately 11:00 a.m. Again, the resident was observed in bed without assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against the contracted hand. A nursing note presented by the facility Interim DON (Director of Nursing) on 1/26/17 dated 10/02/2013 at 6:28 p.m., read that Resident #1 had been refusing Restorative Nursing Program (RNP) care and had been removing splint after application by restorative CNAs (Certified Nursing Assistant). The note stated that Resident #1 was spoken to on this date regarding discontinuation of RNP due to refusals, and reads, "he [Resident #1] is in agreement with this. Will refer to floor CNA for PROM [Passive Range of Motion] and application of splint as [Resident #1] will tolerate." According to the Medical Dictionary, Passive Range of Motion involves someone else moving the joint for you." On 1/24/17 and 1/25/17, Resident #1's clinical record was reviewed. The reviewed showed no current physician's orders pertaining to left hand contracture. Review of the Treatment Administration Record showed no current treatments for Resident #1's contracted left hand. The most current Care Plan presented by the facility staff was reviewed and included the following: Focus: Impaired mobility due to contractures of left hand, bilateral knees and ankle, dx [diagnosis] of hemiparesis. Date initiated	F 318	**F-318 Continued:** **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-service was initiated on 2/7/17 for current nursing staff regarding Care of Residents with hand contractures and range of motion services. This training will be included in orientation of new nursing staff. The Unit Manager or designee will audit residents with hand contractures to ensure range of motion services provided. An Audit will be done weekly four weeks then randomly, reporting findings to the Director of Nursing for appropriate follow-up. **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review above audit reports from the Unit Manager or designee weekly 4 times four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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F 318	Continued From page 41 9/15/2011, Created on 9/15/2011, Revision on 1/16/2017 by MDS Coordinator. Goal: Maintain highest level of function and prevent further degree of contractures by the end of the observation period. Date initiated 9/15/2011, Created on 9/15/2011, Revision on 1/16/2017 by MDS Coordinator, Target date: 4/12/2017. Interventions: Active and passive range of motion of affected extremities PRN [as needed]. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator. Administer pain medication if range of motion is painful prior to starting program. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator. Encourage active participation when possible and praise all efforts. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator. Encourage [Resident #1] to do as much as possible for himself as much as possible during care to enhance joint mobility. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator. Explore possible use of assistive devices to aid mobility. Date initiated 9/15/2011 Created on 9/15/2011, Revision on 9/11/2012 [nothing new added] by MDS Coordinator.	F 318		

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On 1/26/17 facility staff (Administrative-Acting Director of Nursing) presented the following Care Plan regarding Resident #1's Behaviors to address observations made by surveyor and LPN #4 (Resident #1 was observed in bed without assistive device (a carrot or washcloth) in contracted left hand with very long finger nails pressing against and into the contracted hand):

Focus: [Resident #1] has behaviors of yelling out for assistance, refusing care at times, and being physically abusive to staff at times, 8/24/16 refuses bathing. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, Revision on 8/24/2016 [nothing new added] by MDS Coordinator.

Goal: [Resident #1] will continue to show signs of improvements and have all his needs met at this facility.

Interventions included but not limited to:
Explain to [Resident #1] what you are about to do prior to doing it to assist him. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, Revision on 10/21/2012 [nothing new added] by MDS Coordinator.

Offer services when refused in about 10-15 minutes later. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, and no revision date with any new interventions.

Another focus on the most current Care Plan presented by the facility staff included assistance with ADL care.

Focus: [Resident #1] has an ADL care deficit r/t

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[related to] dx [diagnosis] of CVA [stroke] with left sided hemiparesis [weakness]. [Resident #1] requires extensive assistance to complete ADL care.

Interventions included but not limited to :
Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date initiated 9/14/2011, Created on 9/14/2011 by MDS Coordinator, and no revision date with any new interventions.

Bathing: Provide sponge bath on days when a full bath or shower is not given 1/16/17 [Resident #1] frequently refuses to take a shower. Date initiated 9/14/2011 Created on 9/15/2011, Revision on 1/16/2017 [nothing new added since readmission 7/15/2013 until 1/16/2017] by MDS Coordinator.

The ADL task sheets were reviewed for January 2017. The ADL tasks for January 2017 included but were not limited to: Under the title "Personal Hygiene": Gentle ROM [Range of Motion] to left upper extremity and left hand/wrist daily as tolerated. Apply left carrot splint on at all times except for bathing as tolerated. These tasks were to be performed and checked Q [every] shift. Facility staff were not completing the tasks per documentation and interviews.

On 1/26/17 a nursing note was presented by the facility Interim DON dated 10/02/2013 at 6:28 p.m.. The note read, that Resident #1 had been refusing Restorative Nursing Program (RNP) care and had been removing splint after application by restorative CNAs. The note stated that Resident #1 was spoken to on this date regarding discontinuation of RNP due to refusals, and reads, "he [Resident #1] is in agreement with this.

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Will refer to floor CNA for PROM [Passive Range of Motion] and application of splint as [Resident #1] will tolerate." According to a Medical Dictionary, Passive Range of Motion involves someone else moving the joint for you."

Occupational Therapy notes were presented by the Interim DON on 1/26/17. Several quarterly notes from 2017 were presented with notations the exact same with no changes. An OT Daily Treatment Note dated 11/5/2014 read: "Pt's [Patient's] L [left] hand is contracted and he uses a carrot for proper splinting of L hand." An OT Evaluation and Plan of Treatment dated 2/4/2015 identified the following risk factors: "Due to documented physical impairments and associated functional deficits, the patient [Resident #1] is at risk for future decline in function, falls, limited out-of-bed activity and contractures." The OT therapy Progress Report dated 11/2/2014 outlined the onset date of diagnosis (effects of Stroke, muscle weakness) on 10/30/2011 and 3/12/2012 with Treatment (feeding difficulties and lack of coordination) onset date of 11/5/2014. The OT Evaluation and Plan of Treatment dated 1/26/2017 [based on survey findings] noted onset date of diagnosis of contracture and other cerebrovascular disease and treatment for contracture on 1/26/2017.

The OT Assessment dated 1/26/2017 read: "Current value changed from 'Patient presents with pathology consistent with diagnosis of prior CVA with L hand contracture. Patient seen this date with focus on assessment of ROM/nail length/skin integrity." The note continued to report, "Patient subjectively reported pain in his L hand. Therapist requested to see his hand and...explained that she wanted to assess his

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ROM both passively and actively, with patient giving hand to therapist. Upon very gentle ROM and holding his hand, he screamed in pain and became physically aggressive and yelled, 'Just leave it alone.'" The note also documented that patient was shown the carrot orthosis and refused to allow therapist to place it. The conclusion by the therapist was documented and read, "Skilled services not indicated at this time secondary to patient refusing." Nursing was notified regarding patient's subjective high pain levels in left hand.

A review of clinical nursing notes from 11/01/16 through 1/26/17 was conducted on 1/26/17.
On 11/06/2016 a note read, "[Resident #1]...yelling out constantly complained of pain and medicated without results...redirection unsuccessful refused ADL care..."
On 12/24/16 a weekly summary noted: [Resident #1] to be "cooperative with care most of the times, becomes agitated periodically." No mention of PROM or nail care refusal in Clinical Nursing Notes.

On 1/25/17 at approximately 9:05 a.m. Resident #1 was interviewed. Resident #1 stated, "I have arthritis pain in my left hand...the doctor down there in Florida had it better, the doctor had it opened." Resident #1 added, "I try to help myself because I have no therapy and yes my nails are going into my skin but I don't ask them [facility staff] to help...they [facility staff]don't do nothing, no cream and its cold sometimes."

On 1/25/17 at approximately 10:55 a.m. LPN #4 (consistently works with resident) and surveyor interviewed Resident #1. LPN #4 stated, "Yes, his hand is very contracted. Usually he has a carrot or a wash cloth so his nails don't go into his

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hands." LPN #4 also stated, "The carrot is suppose to be in there [Resident #1's contracted hand] all the time. Neither Resident #1 nor LPN #4 could locate the carrot. LPN #4 continued to say, "Yes, his nails need to be cut, they [his nails] are pressing into his hand but no marks." LPN #4 gently observed resident's hand and opened it to see no marks. Resident #1 helped LPN #4 place a washcloth in the contracted hand. Resident #1 yelled in pain initially but when he helped LPN #4 open each finger the wash cloth was able to go into his contracted hand. Resident #1 was cooperative and willing to work with LPN #4. LPN #4 added, "I would use both the carrot and the washcloth to help protect his hand."

On 1/26/17 at 9:13 a.m. an Occupational Therapist was interviewed. The OT stated, "He was evaluated this morning at 7:00 a.m. because nursing was concerned about his hand." The OT explained that Resident #1 complained of a lot of pain and refused ROM and refused the carrot and became aggressive. The OT stated, "I notified nursing of the pain and the refusal, I feel he has behaviors to not allow anything so I handed it over to nursing."

On 1/26/17 at approximately 9:30, CNA #2 (works consistently with Resident #1 on the day shift) was interviewed. CNA #2 stated, "He won't let you do a lot, if he lets me, I put the carrot in his hand and wash it out." CNA #2 explains that she tries daily and if the resident refuses she will document this refusal on the ADL log. CNA #2 stated, "I have not had success with nails...for quite a while, he doesn't like you to touch his hands because it hurts." CNA also explained that she will let the nursing staff know if he is in pain after ADLs. CNA #2 did not know when Resident #1

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receives pain medication. CNA #2 also stated, "I don't know if he is in restorative therapy...ask therapy they would know...and no I don't do range of motion with him."

On 1/26/17 at approximately 9: 35 a.m. LPN #1 (On duty and was told by OT of the Resident#1's pain) was interviewed. LPN #1 stated, "Yes, it was reported to me and I put a note in regarding he OT evaluation." LPN #1 does not work with Resident #1 often. LPN #1 said she went in to talk with the resident around 7: 45 a.m. and he did not want anything for pain. LPN #1 said she would try 2 to 3 times to assist with pain if he refused. LPN #1 said, "I spoke with family a few weeks ago and they feel he may be giving up." LPN #1 stated, "From here I would look at quality of life for him [Resident #1], talk with family, keep him comfortable maybe talk with the doctor about liquid morphine or ativan because liquid is easy to get into people to keep comfortable." LPN #1 said. "Pain is impacting his life so I am going to communicate with the doctor or NP to explore other avenues, like we could schedule medications at 7:30 a.m. prior to ADLs, we could use Norco for break through pain prior to ADLs, or use the Aspercream prior to nail care and placing the carrot, and we could increase the MCGs (Micrograms) on the Fentanyl patch."

A final interview was conducted on 1/26/2017 at 9:45 a.m. with Resident #1. Resident #1 was observed with nails cut and carrot in left hand. Resident #1 said, "Its ok in my hand" [referring to the carrot] and "I want that done [referring to nails cut regularly]." Resident also stated, " I want my nails cut and I want the doctor to tell me its ok-I don't trust them [facility staff]." He added, "It [his left hand] is really painful and I talk about it but

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F 318	Continued From page 48 they don't listen." On 1/26/16 at approximately 10:00 a.m., the DON was interviewed and stated, "LPN #4 cut the nails for Resident #1 and he was fine if he did not watch the nails while cutting but when he looked he would get nervous." Also the DON stated several times that Resident #1 has behaviors and refuses care. The care plan did not reflect any new interventions or attempts or approaches to Resident #1's left hand contracture/ ROM since. Only one Social Work Resident Progress Review was presented regarding Resident #1's behaviors dated 1/5/2016 and when asked for an updated review, the DON stated, "We have none." There was no evidence that Resident #1 was provided ongoing treatment for pain prior to ROM evaluation or prior to ROM exercises to assist with the left hand contracture. No policies were presented regarding ROM treatment and evaluation. The facility administration was informed of the findings during a briefing on 1/26/17 at approximately 11:00 a.m.. The facility did not present any further information about the findings.	F 318		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or	F 329	**F – 329 Deficiency Corrected** (d) Unnecessary Drug-General Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is often when used…….	2/24/17

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F 329	Continued From page 49 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 22 residents was free from unnecessary medications. Resident #11 was on daily doses of the anti-anxiety medication Lorazepam for eleven months without an attempted gradual dose reduction or documented clinical rationale that an attempted dose reduction was contraindicated. The findings include: Resident #11 was admitted to the facility on 7/22/15 with diagnoses that included Alzheimer's, irritable bowel, depression, anxiety and bronchitis. The minimum data set (MDS) dated 1/10/17 assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented a physician's order dated 2/25/16 for the medication Lorazepam 0.5 mg (milligrams) to be administered twice per day for anxiety. Another physician's order dated 2/25/16 was documented for Lorazepam 0.25 mg to be administered once per day for anxiety. The resident's medication	F 329	**F – 329 continued:** **1) How Corrective action will be accomplished for those found to have been effected.** Resident # 11's Drug regimen was reviewed by the Omnicare pharmacist on 1/28/17 and recommendations were conveyed to the attending physician for direction as necessary. Gradual Dose Reduction was received from the physician. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** The Omnicare Pharmacist completed an audit on 2/8/17 of current resident's Psychotropic drug regimen to include recommendation for Gradual Dose Reductions. Any recommendations for adjustments to current physician orders have been submitted to the resident's physician for further review, assessment and order modification as indicated. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** The Omnicare Pharmacist was in-serviced by the Director of Nursing on 2/2/17 as to regulatory and facility's Gradual Dose Reduction expectations. The Unit Manager or designee will review the monthly Pharmacist's report for appropriate Gradual Dose Reductions recommendations for the attending physician's review and direction.	

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F 329	Continued From page 50 administration records (MARs) from 2/25/16 through 1/24/17 documented the resident was administered the Lorazepam three times per day as ordered. Resident #11's clinical record documented no attempted dose reduction of the Lorazepam since 2/25/16. There was no documented clinical justification of why a dose reduction for the Lorazepam was contraindicated. Physician progress notes dated 7/12/16, 9/7/16, 11/2/16 and 12/2/16 documented a reduction in psychoactive medications including Lorazepam was not attempted because "patient continues with anxiety and s/s [signs/symptom] of depression." The record had no documentation indicating the clinical rationale for why an additional attempted dose reduction for Lorazepam would likely impair, cause psychiatric instability or exacerbation of symptoms or a condition. Physician progress notes documented the following assessment/review of Resident #11's psychiatric status. 7/12/16 - "No acute change in mental status or behaviors. Continues with significant anxiety, depression...Memory impaired. Insight and judgement impaired. Difficulty finding words at times. Moderate anxiety. Talkative and interactive. Difficulty focusing on discussion and topic..." 9/7/16 - "No acute change in mental status or behaviors. Continues with significant anxiety, depression...Memory impaired. Insight and judgement impaired. Difficulty finding words at times. Moderate anxiety. Talkative and	F 329	**F – 329 continued:** **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review the pharmacists monthly reports for 3 months reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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F 329	Continued From page 51	F 329		

interactive. Difficulty focusing on discussion and topic..."

11/2/16 - "No change in mental status/behavior...Awake and oriented to person only. Somewhat appropriate and cooperative. Insight/memory impaired. Affect flat and somewhat distant..."

12/2/16 - "...Awake and oriented to person only. Somewhat appropriate and cooperative. Insight/memory impaired. Affect flat and somewhat distant..."

Monthly medication regimen reviews by the facility's pharmacist from March 2016 through December 2016 made no mention of the resident's daily Lorazepam use and included no recommendations concerning a possible attempt at a dose reduction or any documented clinical reasons a dose reduction was contraindicated.

On 1/25/17 at 11:30 a.m. the facility's pharmacist was interviewed about any recommendations concerning an attempted dose reduction for Resident #11's Lorazepam. The pharmacist stated the last attempted gradual dose reduction for Resident #11's Lorazepam was on 11/20/16. When asked what that reduction was, the pharmacist stated he would have to look at his records and advise. The pharmacist was asked why the current order dates for Resident #11's Lorazepam were 2/25/16 if there was a change made on 11/20/16. The pharmacist stated he would look in his records and advise. The pharmacist presented no further information to the survey team about Resident #11's Lorazepam dosage.

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F 329	Continued From page 52 These findings were reviewed with the administrator and director of nursing (DON) during a meeting on 1/25/17 at 4:30 p.m. Further information was requested at this time about any attempted dose reduction for Resident #11's Lorazepam or of any documented clinical justification the dose reduction was contraindicated as the pharmacist had provided no further information about Resident #11. On 1/26/17 at 9:45 a.m. the DON stated Resident #11's last dose reduction for the Lorazepam was on 2/25/16. The DON stated the resident's 0.5 mg dose of Lorazepam was reduced on 2/25/16 from 3 times per day to 2 times per day. The DON stated there were no further attempts at a dose reduction of the Lorazepam since 2/25/16. The DON stated the information stated by the pharmacist of a dose reduction on 11/20/16 was inaccurate. The DON stated the physician documented on progress notes the resident continued with anxiety but there was no further documentation of why another attempted dose reduction was contraindicated. The Drug Information Handbook for Nursing 13th edition on page 743 describes Lorazepam as a benzodiazepine used for the "management of anxiety disorder or short-term ([less than or equal to] 4 months) relief of the symptoms of anxiety or anxiety associated with depressive symptoms." This reference states, "Use with caution in elderly or debilitated patients..." (1) (1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.	F 329		
F 428	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW,	F 428	**F – 428 Deficiency Corrected**	2/24/17

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F 428 SS=D	Continued From page 53 REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 428	**F – 428 Deficiency Corrected** c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior…… **1) How Corrective action will be accomplished for those found to have been effected.** Resident # 11's Drug regimen was reviewed by the Omnicare pharmacist on 1/28/17 and recommendations were conveyed to the attending physician for direction as necessary. Gradual Dose reduction was received from the physician. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** The Omnicare Pharmacist completed an audit on 2/8/17 of current resident's Psychotropic drug regimen to include recommendation for Gradual Dose Reductions. Any recommendations resulting have been submitted to the resident's physician for further interventions.	

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F 428	Continued From page 54 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to make a pharmacy recommendation for one of 22 residents in the survey sample. Pharmacy failed to make a recommendation concerning an attempted dose reduction for Resident #11's ongoing use of the anti-anxiety medication Lorazepam. The findings include: Resident #11 was admitted to the facility on 7/22/15 with diagnoses that included Alzheimer's, irritable bowel, depression, anxiety and bronchitis. The minimum data set (MDS) dated 1/10/17 assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented a physician's order dated 2/25/16 for the medication Lorazepam 0.5 mg (milligrams) to be administered twice per day for anxiety. Another physician's order dated 2/25/16 was documented for Lorazepam 0.25 mg to be administered once per day for anxiety. The resident's medication administration records (MARs) from 2/25/16	F 428	**F – 428 Continued:** **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** The Omnicare Pharmacist was in-serviced by the Director of Nursing on 2/2/17 to regulatory and facility Gradual Dose Reduction expectations. The Unit Manager or designee will review the monthly Pharmacist's report for appropriate Gradual Dose Reductions recommendations for the attending physician's review and direction. **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review monthly pharmacists reports, reporting findings to the monthly Quality Assurance Committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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F 428	Continued From page 55	F 428		

through 1/24/17 documented the resident was administered the Lorazepam three times per day as ordered.

Resident #11's clinical record documented no attempted dose reduction of the Lorazepam since 2/25/16. There was no documented clinical justification of why a dose reduction for the Lorazepam was contraindicated. Physician progress notes dated 7/12/16, 9/7/16, 11/2/16 and 12/2/16 documented a reduction in psychoactive medications including Lorazepam was not attempted because "patient continues with anxiety and s/s [signs/symptom] of depression." The record had no documentation indicating the clinical rationale for why an additional attempted dose reduction for Lorazepam would likely impair, cause psychiatric instability or exacerbation of symptoms or a condition.

Physician progress notes documented the following assessment/review of Resident #11's psychiatric status.

7/12/16 - "No acute change in mental status or behaviors. Continues with significant anxiety, depression...Memory impaired. Insight and judgement impaired. Difficulty finding words at times. Moderate anxiety. Talkative and interactive. Difficulty focusing on discussion and topic..."

9/7/16 - "No acute change in mental status or behaviors. Continues with significant anxiety, depression...Memory impaired. Insight and judgement impaired. Difficulty finding words at times. Moderate anxiety. Talkative and interactive. Difficulty focusing on discussion and

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F 428	Continued From page 56	F 428		

topic..."

11/2/16 - "No change in mental status/behavior...Awake and oriented to person only. Somewhat appropriate and cooperative. Insight/memory impaired. Affect flat and somewhat distant..."

12/2/16 - "...Awake and oriented to person only. Somewhat appropriate and cooperative. Insight/memory impaired. Affect flat and somewhat distant..."

Monthly medication regimen reviews by the facility's pharmacist from March 2016 through December 2016 made no mention of the resident's daily Lorazepam use and included no recommendations concerning a possible attempt at a dose reduction or any documented clinical reasons a dose reduction was contraindicated.

On 1/25/17 at 11:30 a.m. the facility's pharmacist was interviewed about any recommendations concerning an attempted dose reduction for Resident #11's Lorazepam. The pharmacist stated the last attempted gradual dose reduction for Resident #11's Lorazepam was on 11/20/16. When asked what that reduction was, the pharmacist stated he would have to look at his records and advise. The pharmacist was asked why the current order dates for Resident #11's Lorazepam were 2/25/16 if there was a change made on 11/20/16. The pharmacist stated he would look in his records and advise. The pharmacist presented no further information to the survey team about Resident #11's Lorazepam dosage.

These findings were reviewed with the

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F 428	Continued From page 57 administrator and director of nursing (DON) during a meeting on 1/25/17 at 4:30 p.m. Further information was requested at this time about any attempted dose reduction for Resident #11's Lorazepam or of any documented clinical justification the dose reduction was contraindicated as the pharmacist had provided no further information about Resident #11. On 1/26/17 at 9:45 a.m. the DON stated Resident #11's last dose reduction for the Lorazepam was on 2/25/16. The DON stated the resident's 0.5 mg dose of Lorazepam was reduced on 2/25/16 from 3 times per day to 2 times per day. The DON stated there were no further attempts at a dose reduction of the Lorazepam since 2/25/16. The DON stated the information stated by the pharmacist of a dose reduction on 11/20/16 was inaccurate. The DON stated the physician documented on progress notes the resident continued with anxiety but there was no further documentation of why another attempted dose reduction was contraindicated. The Drug Information Handbook for Nursing 13th edition on page 743 describes Lorazepam as a benzodiazepine used for the "management of anxiety disorder or short-term ([less than or equal to] 4 months) relief of the symptoms of anxiety or anxiety associated with depressive symptoms." This reference states, "Use with caution in elderly or debilitated patients..." (1) (1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	**F – 431 Deficiency Corrected**	**2/24/17**

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F 431	Continued From page 58 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	**F – 431 Deficiency Corrected** The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. **1) How Corrective action will be accomplished for those found to have been effected.** Resident #1, #5, #9 and #13 have been assessed and determined to have had no adverse clinical issues related to the possible non-receipt of unaccounted for medications. Resident #10 and Resident #14's Control Medication Utilization Records were determined to be calculation errors on the part of the Nurses; the Nurses involved received 1on1 re-education on 1/25/17 including how to accurately subtract and document on a declining Controlled Medication Utilization Record. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** The current resident's medication supplies were audited to determine if there have been further unaccounted for medications or Controlled Medication Utilization Records out of compliance with count. The audit was completed on 2/10/17; no new instances have been identified through this audit.	

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F 431	Continued From page 59 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on, staff interview, clinical record review, and facility document review the facility staff failed to implement a system of records and deposition of controlled medications for four of 22 resident's, Resident #'s 9, 13, 5, 1, 14 and 10. 1. Resident #9's Norco (schedule 2 narcotic) could not be accounted for. 2. Resident #13's Oxycodone (schedule 2 narcotic) could not be accounted for. 3. Resident #5's Percocet (schedule 2 narcotic) could not be accounted for. 4. Resident #1's Norco (schedule 2 narcotic) could not be accounted for. 5. The facility staff failed to ensure accurate dispensing, administering, storage and reconciliation of a Schedule IV (4) narcotic medication for Resident # 14. 6. The facility staff failed to ensure accurate	F 431	**F – 431 Continued:** **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** Reeducation was initiated on 2/10/17 for current licensed nurses to include the new implemented process for the counting and verification of medication cards for each resident by each shift. This will be included in the orientation process of new licensed nursing staff. **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will randomly monitor the change of shift counting of medications to ensure the newly implemented process is being complied with by the licensed staff weekly 4 times for four weeks covering the three shifts. Audit findings will be reported to the monthly Quality Assurance Committee and then randomly or on an as needed based on the recommendations of the Quality Assurance Committee.	

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reconciliation of a Schedule IV (4) narcotic medication for Resident # 10.

Findings include:

1. Resident #9's Norco (schedule 2 narcotic) could not be accounted for.

Resident #9 was admitted to the facility on 3/5/15 with a readmission on 6/22/15 with diagnoses including chronic pain, neuropathy (peripheral nerve damage), and osteoporosis (bone loss).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/10/17. Resident #9 was assessed as being moderately cognitively intact.

A facility reported incident (FRI) for Resident #9 dated 8/17/16 was reviewed concerning 26 missing doses of Norco for the month of August 2016.

Resident #9's electronic record was reviewed and documented per physician orders that Norco was scheduled to be given, 1 tablet three times a day and two tablets at night for pain. Review of Resident #9's medication administration record for August 2016 indicated that Resident #9 received the medication as ordered.

On 1/25/17 at 8:15 a.m. the current interim director of nursing (DON) and the acting DON (at the time of the incident, identified as registered nurse, RN #1) was interviewed. RN #1 verbalized the reason for the FRI was due to the uncovering of multiple drug diversions identified upon the previous DON's resignation secondary to unaccounted documentation of narcotic count

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sheets.

RN #1 explained the process of how the facility accounted for narcotics coming into the facility as follows:
The facility receives narcotics from the pharmacy and the shift nurses are supposed to count the medications reconciling the count against the pharmacy manifest, the manifest is signed off with a copy going back to the pharmacy and a copy going into a mail box for the DON to pick up and file.

The medications come on a medication card (a card usually has 30 pills to a card) and each card has a count down sheet (every time a pill is administered the nurse documents on the count down sheet) the pills on the card should match the number of pills documented on the count down sheet.

Once all the pills have been dispensed from the card and the count down sheet balance is zero, the count down sheet is then put into the DON's mail box, the DON attaches the count down sheet to the original manifest to evidence completion and then is kept on file.

RN #1 was asked how did the process fail. RN #1 verbalized that when a physician orders Norco (for example) he may order 120 pills which would render 4 cards of pills with 30 pills to a card totaling 120 pills. For each card of pills there is a count down sheet (4 count down sheets). RN #1 went onto verbalized when the previous DON resigned, there was a lot of un-filed narcotic manifest's that where missing count down sheets so medications could not be accounted for.

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RN #1 speculated that whoever was taking the medications was also taking the count down sheets so that a nurse doing a count of narcotics would only be counting what was on hand against that particular count down sheet. RN #1 agreed with the surveyor, because of the poor filing system, medications could not be accounted for.

On 1/25/17 at 11:40 a.m. the survey team interviewed the pharmacist (other staff, OS #1) regarding the above finding. OS #1 verbalized that the staff nurses should be accounting for narcotics from shift to shift to account for all narcotics. As far as pharmacy services, the pharmacist will conduct a random narcotic count on a quarterly basis to ensure accuracy.

OS #1 was asked if the pharmacy would be able to identify narcotics being ordered sooner than they were supposed to be ordered to detect over usage or possible drug diversion (due to the supply on hand at the facility has been used up). OS #1 verbalized that it should show in the pharmacy system to ensure medications wasn't being ordered early. OS #1 was not able to confirm or provide documentation that the pharmacy was tracking narcotics being ordered early.

No other information was provided prior to exit conference on 1/26/17.

2. Facility staff failed to account for 13 doses of the opioid medication Oxycodone for Resident #13.

Resident #13 was admitted to the facility on 10/1/15 with a re-admission on 11/25/16. Diagnoses for Resident #13 included heart

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failure, Alzheimer's, anxiety, depression, pneumonia and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 12/6/16 assessed Resident #13 with severely impaired cognitive skills.

Five facility reported incidents were received by the state agency in August 2016 documenting an investigation of possible drug diversion involving multiple residents. A follow-up letter from the facility dated 9/28/16 documented Resident #13 was missing 13 doses of the opioid medication Oxycodone in April 2016. The letter stated the facility received 15 prescribed doses of Oxycodone for Resident #13 on 3/31/16. The resident's April medication administration record documented a dose was administered to Resident #13 on 4/5/16 and another dose given on 4/8/16. The facility letter documented at the time of the investigation no count sheet was found for Resident #13's Oxycodone delivered on 3/31/16 and the remaining 13 doses of the Oxycodone were missing and not located.

Resident #13's clinical record documented a physician's order dated 2/16/16 for Oxycodone 2.5 milligrams (mg) to be administered every 4 hours as needed for pain. The resident's MAR for April 2016 documented a dose administered on 4/5/16 and on 4/8/16 as listed in the facility's investigation.

On 1/25/17 at 9:35 a.m. the registered nurse (RN #1) that served as interim director of nursing during the drug diversion investigation was interviewed about Resident #13. RN #1 stated they discovered the diversion in August 2016 and then reviewed all records back to January 2016 as part of their investigation in an attempt to

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account for the medications. RN #1 stated they never found a count sheet for Resident #13's Oxycodone that was delivered and received at the facility on 3/31/16. RN #1 stated the resident's April 2016 MAR documented a dose of Oxycodone was administered to the resident on 4/5/16 and an additional dose on 4/8/16. RN #1 stated the remaining 13 pills of Oxycodone were never found. RN #1 stated concerning Resident #13's Oxycodone, "The entire count sheet and meds [medicine] were missing." RN #1 stated Resident #13's missing Oxycodone was part of a facility issue with missing controlled medicines involving multiple residents in the facility.

The Drug Information Handbook for Nursing 13th edition on pages 912 and 913 describes Oxycodone as an opioid analgesic used for the management of moderate to severe pain. This reference states, "This Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have a heightened risk of causing significant patient harm when used in error... Healthcare provider should be alert to problems of abuse, misuse, and diversion." (1)

The U.S. Drug Enforcement Administration (DEA) lists Oxycodone in the schedule II drug classification. The DEA website states, "Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychosocial or physical dependence. These drugs are also considered dangerous." (2)

These findings were reviewed with the administrator and director of nursing during a meeting on 1/25/17 at 4:30 p.m.

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(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

(2) Drug Schedules. U.S. Drug Enforcement Administration. U.S. Department of Justice. 1/27/17. <https://www.dea.gov/druginfo/ds.shtml>

3. Facility staff failed to keep an accurate record and disposition of Percocet for Resident #5 from 05/27/16 through 08/08/16, resulting in 368 unaccounted Percocet tablets and 18 narcotic count sheets.

Resident #5 was originally admitted to the facility on 05/24/16 and readmitted on 06/11/16 with diagnoses including, but not limited to: Anxiety, Hypertension, Congestive Heart Failure, Neuropathy, Diabetes and Chronic Pain.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/29/16. Resident #5 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #5's EMR (electronic medical record) was reviewed on 01/25/17 at 8:15 a.m. Physician Order Sheets (POS's) dated 05/01/16 through 08/31/16 were reviewed. Specific physician orders for Percocet during that time period included:

05/25/2016 - 05/28/2016: "Percocet Tablet 10-325 MG (milligrams) (Oxycodone-Acetaminophen) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Severe Pain..."

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05/28/2016 - 06/04/2016: "Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) Give 1 tablet by mouth every 6 hours for pain..."

06/04/2016 - 06/13/2016: "Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) Give 1 tablet by mouth every 4 (four) hours for chronic pain one tablet Q4 (every four) hours while awake and one tablet Q4 as needed for pain during the night AND Give 1 tablet by mouth every 4 hours as needed for chronic pain..."

06/13/2016 - 08/05/2016: "Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) Give 1 tablet by mouth every 4 hours for chronic pain one tablet Q4 hours while awake and one tablet Q4 hours as needed for pain during the night..."

06/13/2016 - 08/05/2016: "Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain..."

08/05/2016 - 01/19/2017: "Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) Give 1 tablet by mouth as needed for sever (sic) pain ****MAY ONLY BE GIVEN BETWEEN THE HOURS OF 2400-0400**** (12:00 a.m. - 4:00 a.m.) AND Give 1 tablet by mouth four times a day for severe pain..."

Review of the MAR's for the same time frame did not reveal any missed doses of Percocet, scheduled or prn (as needed).

On 01/25/2017 at 11:40 a.m. the facility contract pharmacist was interviewed by the survey team. The pharmacist stated he had been coming to the

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facility since January 2016. His pharmacy took over the building in February 2016. During January he was there to help with the transition from one pharmacy to other. The pharmacist stated, "I was notified of the investigation of a possible drug diversion in August 2016. I immediately alerted my pharmacy." Regarding his responsibility to prevent drug diversions the pharmacist stated, "I cannot personally stop drug diversion. The pharmacy does quarterly checks. I review all records monthly. I check unattended med (medication) carts to make sure they are locked. The pharmacy nurse is in and does random checks as well." Regarding delivery of narcotics to the facility the pharmacist stated, "Controlled drugs are delivered to the facility in special packages. The nurse visualizes the packages verifying the correct dose and count. The nurse then signs for the drugs. The facility receives a tracking manifest with each delivery." Regarding the reason controlled medications are delivered in such large quantities the pharmacist stated, "It has a lot to do with insurance. If a resident has Medicaid and some types of Part D insurance they do not recognize the difference between long term care pharmacies and retail pharmacies. Partial prescription fills are not recognized. For Medicaid you must have a hard script for all controlled medications. If a prescription is partially filled the remainder of the script is void and a new hard script would be needed before the medication can be refilled."

At approximately 3:00 p.m. RN #1 (registered nurse) was interviewed regarding the investigation of Resident #5's missing Percocet tablets and narcotic count sheets. RN #1 stated, "I took over as the interim DON (director of nursing) last July. As I was going through papers

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in the office I discovered pharmacy manifest sheets stuck everywhere. Part of the DON job is to reconcile the pharmacy manifest sheets with the controlled meds received. As we (the facility) were trying to reconcile all these sheets we noticed the manifest sheets, narcotic count sheets and doses of drugs were not matching up. I alerted the Administrator and he had us go back to January 1 and audit all the narcotics received with the pharmacy manifest sheets. It took us about three weeks working everyday to come up with what we did. Everyone was notified, corporate, the police, your office, pharmacy board, nursing board, etc. (Name) Resident #5 never missed any doses because of the amount of Percocet that was delivered for her every time. As we discovered the problem we immediately starting implementing new procedures for accepting controlled drugs from the pharmacy and have continued to implement new things as needed. I am happy to say we have not had any missing medications or narcotic count sheets since September of last year."

No further information was received by the survey team prior to the exit conference on 01/26/2017.

4. For Resident # 1, the facility staff failed to account for 295 missing Norco pills from May 2016 through August 2016.

Resident # 1 was re-admitted to the facility on 7/15/2013. Diagnoses for Resident # 1 included but are not limited to cerebrovascular disease (history of a stroke), contracture unspecified hand (left), hemiplegia (one side weakness), pain, osteoarthritis, depression, and unspecified psychosis not due to a substance or known physiological condition. Resident # 1's Minimum

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Data Set (an assessment protocol) with an Assessment Reference Date of 1/3/17 coded Resident # 1 with inattention and disorganized thinking with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident # 1 requiring extensive assistance and total dependence, on staff for Activities of Daily Living (bed mobility, dressing, and hygiene/bathing) care.

On 1/25/2017 and 1/26/2017, Resident #1's clinical record was reviewed. The reviewed showed a physician order dated 5/16/2016. The order read, Resident #1 was to get Hydrocodone-Acetaminophen (Norco) 7.5-325 MG (Milligrams). The instructions read: Give 1 Tablet by mouth three times a day for pain and every 4 hours as needed for pain. This physician's order was present on Resident #1's Medication Review Report from May 2016 through August 2016.

A review of Residents #1's Medication Administration Record for the months of May, 2016 through August 2017 documented that Resident #1 received Norco daily and as needed for pain.

During a facility investigation in August 2016, the DON (Director of Nursing) and current MDS Coordinator found the following Norco pills missing and documented:

May 2016: On 5/6/16 60 Norco pills were received. On 5/15/16 at 2230 (10:30 p.m.) the card of 30 was finished. Another card was not started until 5/21/16 at 1600 (4:00 p.m.) per the MAR. 30 pills were accounted for on the declining count sheet and 18 administrations were given

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according to the MAR. 12 pills were missing.

June 2016: On 6/13/16 180 Norco pills were received. On 7/7/16 at 17:29 (6:29 p.m.) the card of 30 was finished. Another card was started on 7/11/16 at 17:29 (6:29 p.m.). Per the MAR 11 administrations were given between 7/8 and 7/11/16. 49 pills were missing.

July 2016: On 7/5/16 120 Norco pills were received. On 7/26/16 at 17:16 (6:16 p.m.) the card of 30 was finished. Another card was started on 8/4/16 at 2152 (9:52 p.m.). Per the MAR 28 administrations were given between 7/26 and 8/4/16. 32 pills were missing.

August: On 7/20/16 120 Norco pills were received. On 8/12/16 at 0947 (9:47 a.m.) the card of 30 was finished. Another card was started on 8/15/16 at 0948 (9:28 a.m.). Per the MAR 8 administrations were given between 8/12/16 and 8/14/16. No declining count sheets were found. 112 pills were missing.

August: On 7/31/16 90 Norco pills were received. On 8/15/16 the declining count sheets were accurate. Since then only 1 declining count sheet was located. 60 pills were missing.

A total of 295 Norco pills were unaccounted for from May 2016 through August 2016.

On 1/24/17 at approximately 4:10 p.m. RN#1 (Registered Nurse) was interviewed. RN#1 stated that she worked hard to investigate and account for the missing pills. RN #1 also stated that documentation was missing along with the pills which made it difficult to keep track. RN #1 added, "Residents did not miss any doses as we

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had more than enough medication." The problem was that the prescribing doctor would prescribe more than enough medications and someone (or a group) would take some pills and the counting sheets.

On 1/25/17 at approximately 11:00 a.m. the Pharmacist (Others #1) was interviewed by the entire survey team. Others #1 explained that a monthly and quarterly review is conducted by Pharmacy staff in the facility. Others #1 added, "Pharmacy Services send medications in package and the receiving nurse signs to ensure the number is accounted for and received. Tracking occurs from shift to shift. Once the pharmacy has the Manifest Tracking signed, then we have proof of delivery. Then nursing counts with sheets and pharmacy reviews on a quarterly basis unless a medication needs to be sent back or destroyed." Others #1 added, "We [Pharmacy] are not counting controls every month...I [Others #1] will review what nursing documents on a quarterly basis." Finally, the pharmacist admitted, "We didn't catch this [drug diversion] until notified by the facility staff." No policies were submitted by the pharmacy when asked for procedures: Others #1 stated, "We follow the Board of Pharmacy."

On 1/25/17 at approximately 2:50 p.m. the interim Administrator stated, "We [facility staff] worked tirelessly on this [drug diversion]." The Administrator added, "Local concerns have been dealt with...the police were notified, the Ombudsman was notified, DHP [Department of Health Professions] was notified, and we sent in FRIs [Facility Reported Incidences] to the state. Also, staff members were interviewed and drug tested and some staff are no longer at the facility as a result of the police investigation." The

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Administrator also mentioned that the corporate/risk management team for the facility are still in process and had not finalized working with pharmacy to correct the process. The facility Administration stated that the DEA (Drug Enforcement Agency) was involved and that staff had cooperated on every level to assist authorities in the investigation. The facility staff also conducted its own investigation and reported findings to the appropriate authorities.

The facility administration was informed of the findings during a briefing on 1/26/17 at approximately 11:00 a.m. The facility did not present any further information about the findings.

5. The facility staff failed to ensure accurate dispensing, administering, storage and reconciliation of a Schedule IV (4) narcotic medication for Resident # 14.

Resident # 14 was admitted to the facility on 06/14/14, with the most current readmission on 08/15/15. Diagnoses for Resident # 14 included, but were not limited to: dementia, anxiety disorder, psychotic disorder, schizophrenia, and seizure disorder.

The most current MDS (minimum data set) was a quarterly assessment dated 11/08/16, which assessed the resident as having a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills.

On 01/25/17 the facilities medication carts on A wing were observed at approximately 11:15 a.m.

RN (Registered Nurse) # 2 was asked to explain the process for narcotic administration. RN # 2

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stated that first she looks at the computer to ensure the order, then retrieves the 'sign out' narcotic book from the side of the medication cart and turns to the resident's page for that medication, verifies and then opens the narcotic drawer and retrieves the medication, sign's it out in the book and then administers it.

RN # 2 was asked to give a demonstration. RN # 2 opened the narcotic book and turned to Resident # 14's page.

Resident # 14's page listed the drug as "diazepam [a schedule IV/4 medication] with lure lock 5 mg/1 ml [milligrams/milliliter] DISP SYRIN M GIVE (0.2 ML INTRAMUSCULAR NOW * THEN GIVE (0.2 ML) EVERY 30 MIN AS NEEDED FOR 3 DAYS FOR SEIZURES" The page documented the date received as 11/14/16, the quantity (received) was 5 pens/syringes-10 mg in each pen/syringe.

RN # 2 opened the narcotic drawer and pulled out a Ziploc bag. The RN stated that this is the only one left in this bag, she started out with 5 and this is what is left of this order. Inside the bag was one manufactured, glass pen/syringe in a plastic tubular sleeve. The pen/syringe was removed and observed as a 10 mg/2 ml pen/syringe. The syringe had "graduation marks" (units of measure/scale markings listed in cubic centimeters of milliliters), which are marks to indicate the amount left in the syringe. This pen/syringe was observed with 1.5 ml remaining (meaning that .5 ml had been administered to the resident). The nurse was then asked how they (staff nurses) administer this medication and was asked if the nurses use a standard syringe to draw the medication out of the glass syringe or do

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they attach a needle to the end of the glass syringe and administer that way. The RN stated, "Well it's IM [intramuscular], I really don't know I have never administered it [from the glass syringe] before."

The glass syringe was observed again and did not have any information on the actual package to indicate that this was a multi dose syringe. The RN was asked if they (staff nurses) just use what is needed and then store the unused medication back in the cart. The RN stated, "It looks that way." The RN was asked to provide a manufacturer's package insert for this medication. The RN stated that she would notify the pharmacy to have the information faxed.

At approximately 12:15 p.m., the facility pharmacist and the corporate DON (director of nursing) were asked to observe the above findings and to clarify if the glass syringe was to be used as a multi dose vial. RN # 2 removed the medication from the locked narcotic drawer and handed the medication to the pharmacist. The pharmacist stated, "If it has a needle then that would be a single dose." The glass syringe was then taken out of the plastic tube and the top removed, there was no needle.

The pharmacist then stated that the package should actually say if it is a multi dose syringe and went on to say, "It does not." The corporate RN stated that the rest of the medication in that syringe should have been wasted when the last dose was administered on 01/16/17.

At approximately 12:30 p.m., the package insert for the above medication was presented. The package insert information documented, "...How

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F 431	Continued From page 75 Supplied: Carpuject Sterile Cartridge Unit with Luer Lock...Concentration 10 mg/2 ml (5 mg/1 ml)...Carpuject [TM/trademark], Single-dose cartridge with Luer Lock for the Carpuject Syringe System..." Upon further review of Resident # 14's narcotic sheet for diazepam, it was found that the narcotic count of this medication was off by 0.3 ml between 12/29/16 and 01/06/17, the medication was unaccounted for, there was no record of administration or of the medication being wasted. At approximately 3:30 p.m., the above information and concerns were discussed with the administrator and corporate DON. Both agreed that the medication syringe should only have been accessed one time and then any remaining medication should have been destroyed per facility policy, since these were single dose medication units. No explanation was provided regarding the medication count/reconciliation of the unaccounted for 0.3 ml of the diazepam for Resident # 14. A policy was requested on medication administration, as far as infection control practices and use of single or multi- dose medication units. At approximately 4:15 p.m., the corporate DON stated that the facility did not have specific policy, as requested above but did have a paid subscription to a nursing resource that they (the facility) uses for reference and presented an insert titled, "Injectable Medication Administration", was presented and documented: "...The Association of Professionals in Infection and Control and Epidemiology guideline and the World Health Organization recommend using single-use or single-dose vials whenever	F 431		

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F 431	Continued From page 76 possible. A multidose vial poses a risk of transmission by inappropriate handling...Always follow manufacturer's instructions for storage and use of medication vials and label multidose vials with the date immediately upon opening. To reduce the risk of contamination, most facilities dispense parenteral medications in single-dose vials...you should only use multidose vials only if there's no alternative...You should use vials labeled by the manufacturer as "single dose" or "single use" for a single patient only. These medications lack antimicrobial preservatives and can become contaminated and serve a source of infection if used inappropriately...Record the drugs administered, injection site, and time of administration..." No further information or documentation was provided prior to the exit conference on 01/26/17 at 12:00 p.m. 6. The facility staff failed to ensure accurate reconciliation of a Schedule IV (4) narcotic medication for Resident # 10. Resident # 10 was admitted to the facility on 12/17/15, with diagnoses including, but not limited to: spinal stenosis, DM (diabetes mellitus), anemia, migraines, chronic kidney disease, and osteomyelitis. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 11/19/16, which assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills.	F 431		

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On 01/25/17 at approximately 12:26 p.m., the other med cart on A wing was observed with RN # 5. RN # 5 was asked if there were any injectables on this medication cart. RN # 5 stated that there was no injectables on the cart, only a bottle of liquid morphine. The RN was asked to observe that medication and the narcotic medication log.

RN # 5 pulled the medication bottle from the locked drawer and opened the narcotic log book to Resident # 10. The narcotic log sheet and the morphine bottle for Resident # 10 documented that the morphine sulfate was supplied in a 30 ml bottle, with a concentration of 20 mg/1 ml. The ordered dose for Resident # 10 was, "Take 0.5 ml (10 mg) by mouth every hour as needed for pain/dyspnea [shortness of breath]..."

The morphine bottle came with a graduated syringe to measure the dose to be given in 0.5 ml [10 mg] increments.

Resident # 10's narcotic log sheet was reviewed and documented the following:

On 12/30/16 the amount documented as given was 0.5 ml (10 mg) and the amount remaining was 22 ml.

On 12/31/16 the amount documented as given was 0.5 ml (10 mg) and the amount remaining was 21 ml. This showed an error in calculation or administration of 0.5 ml.

On 01/19/17 at 9:00 p.m., the amount documented as given was 0.5 ml (10 mg) and the amount remaining was 8 ml.

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F 431	Continued From page 78 On 01/19/17 at 11:23 p.m., a handwritten notation was made that documented, "Dosage adjustment." This was signed by two nurses on the 11-7 shift, which documented the remaining amount of morphine to be 5 mls, which left an unaccounted for amount of 3 mls. The total amount unaccounted amount per the documentation was 3.5 mls. RN # 5 could not explain the discrepancies found. The corporate DON and the administrator were made aware in a meeting with the survey team on 01/25/17 at approximately 4:30 p.m. The corporate DON was unaware of the identified information above. No information or documentation was provided to explain the discrepancies. No further information or documentation was provided prior to the exit conference on 01/26/17 at 12:00 noon.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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	F 441	**F – 441 Deficiency Corrected** (a)…Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) the must include, 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 agreement based upon the facility assessment conducted according to §483.70(e) and following acceptable national standards (facility assessment implementation in Phase2);….	2/24/17

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F 441	Continued From page 79 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 (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.	F 441	**F – 441 Continued:** **1) How Corrective action will be accomplished for those found to have been effected.** Resident #14's medication was reviewed on 1/26/17; the medications was discontinued by the physician. **2) How corrective action will be accomplished for those having potential to be affected by the same practice.** An audit of the single use Valium vial was completed 1/25/17, no other residents were determined to be affected. **3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.** In-service was initiated on 2/7/17 for the current licensed nursing staff to include proper administration of a single dose medication vial and any leftover contents disposed of as per facility protocol. This will be included in Orientation of new licensed nursing staff. The Unit manager or designee will monitor compliance with the use of single dose vial medication protocol a minimum weekly 4 weeks than randomly thereafter reporting findings to the Director of Nursing for appropriate follow-up.	

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F 441	Continued From page 80 (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 ensure proper dispensing and storage of medication for the prevention of contamination for one of 22 residents in the survey sample, Resident # 14. The facility staff failed to follow manufacturer's instructions for the use of single use diazepam syringes for Resident # 14; the facility staff accessed the single dose units multiple times and put the medication at risk for contamination and the resident at risk of infection. Findings include: Resident # 14 was admitted to the facility on 06/14/14, with the most current readmission on 08/15/15. Diagnoses for Resident # 14 included, but were not limited to: dementia, anxiety disorder, psychotic disorder, schizophrenia, and seizure disorder. The most current MDS (minimum data set) was a	F 441	**F – 441 Continued:** **4) How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will review audit reports on a weekly basis for four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or on an as needed based on the recommendations of the Quality Assurance Committee.	

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quarterly assessment dated 11/08/16, which assessed the resident as having a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills.

On 01/25/17 the facilities medication carts on A wing were observed at approximately 11:15 a.m.

RN (Registered Nurse) # 2 was asked to explain the process for narcotic administration. RN # 2 stated that first she looks at the computer to ensure the order, then retrieves the 'sign out' narcotic book from the side of the medication cart and turns to the resident's page for that medication, verifies and then opens the narcotic drawer and retrieves the medication, sign's it out in the book and then administers it.

RN # 2 was asked to give a demonstration. RN # 2 opened the narcotic book and turned to Resident # 14's page.

Resident # 14's page listed the drug as "diazepam [a schedule IV/4 medication] with lure lock 5 mg/1 ml [milligrams/milliliter] DISP SYRIN M GIVE (0.2 ML INTRAMUSCULAR NOW * THEN GIVE (0.2 ML) EVERY 30 MIN AS NEEDED FOR 3 DAYS FOR SEIZURES" The page documented the date received as 11/14/16, the quantity (received) was 5 pens/syringes-10 mg in each pen/syringe.

RN # 2 opened the narcotic drawer and pulled out a Ziploc bag. The RN stated that this is the only one left in this bag, she started out with 5 and this is what is left of this order. Inside the bag was one manufactured, glass pen/syringe in a plastic tubular sleeve. The pen/syringe was removed and observed as a 10 mg/2 ml pen/syringe. The

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syringe had "graduation marks" (units of measure/scale markings listed in cubic centimeters of milliliters), which are marks to indicate the amount left in the syringe. This pen/syringe was observed with 1.5 ml remaining (meaning that 0.5 ml had been administered to the resident). The nurse was then asked how they (staff nurses) administer this medication and was asked if the nurses use a standard syringe to draw the medication out of the glass syringe or do they put a needle on the end of the glass syringe and administer that way. The RN stated, "Well it's IM [intramuscular], I really don't know I have never administered it [from glass syringe] before."

The glass syringe was observed again and did not have any information on the actual package to indicate that this was a multi dose syringe. The RN was asked if they (staff nurses) just use what is needed and then store the unused medication back in the cart. The RN stated, "It looks that way." The RN was asked to provide a manufacturers package insert for this medication. The RN stated that she would notify pharmacy to have the information faxed.

At approximately 12:15 p.m., the facility pharmacist and the corporate DON (director of nursing) were asked to observe the above findings and to clarify if the glass syringe was supposed to be used as a multi dose vial. RN # 2 removed the medication from the locked narcotic drawer and handed the medication to the pharmacist. The pharmacist stated, "If it has a needle then that would be a single dose." The glass syringe was then taken out of the plastic tube and the top removed, there was no needle. The pharmacist then stated that the package should actually say if it is a multi dose syringe and

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went on to say, "It does not." The corporate RN stated that the rest of the medication in that syringe should have been wasted when the last dose was administered.

At approximately 12:30 p.m., the package insert for the above medication was presented. The package insert information documented, "...How Supplied Carpuject Sterile Cartridge Unit with Luer Lock...Concentration 10 mg/2 ml (5 mg/1 ml)...Carpuject [TM/trademark], Single-dose cartridge with Luer Lock for the Carpuject Syringe System..."

Upon further review of Resident # 14's narcotic sheet for diazepam, it was found that the narcotic count of this medication was off by 0.3 ml between 12/29/16 and 01/06/17, there was no record of administration or of the medication being wasted.

The above information and concerns were discussed with the administrator and corporate DON. Both agreed that the medication syringe should only have been accessed one time and then any remaining medication should have been wasted, since these were single dose medication units. No explanation was provided regarding the medication count/reconciliation of the unaccounted for 0.3 ml of the diazepam for Resident # 14.

At approximately 4:15 p.m., the corporate DON stated that the facility did not have specific policy, as requested above but did have a paid subscription to a nursing resource that they (the facility) uses for reference and presented an insert titled, "Injectable Medication Administration", was presented and documented:

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AVANTE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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 441	Continued From page 84 "...The Association of Professionals in Infection and Control and Epidemiology guideline and the World Health Organization recommend using single-use or single-dose vials whenever possible. A multidose vial poses a risk of transmission by inappropriate handling...Always follow manufacturer's instructions for storage and use of medication vials and label multidose vials with the date immediately upon opening. To reduce the risk of contamination, most facilities dispense parenteral medications in single-dose vials...you should only use multidose vials only if there's no alternative...You should use vials labeled by the manufacturer as "single dose" or "single use" for a single patient only. These medications lack antimicrobial preservatives and can become contaminated and serve a source of infection if used inappropriately...Record the drugs administered, injection site, and time of administration..." No further information or documentation was provided prior to the exit conference on 01/26/17 at 12:00 p.m.	F 441		