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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/09/17 through 05/11/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 17 Residents, 14 current Resident reviews (Resident #1 through Resident #14) and 3 closed record reviews (Resident #15 through Resident #17).	F 000		
F 159 SS=E	FACILITY MANAGEMENT OF PERSONAL FUNDS CFR(s): 483.10(f)(10)(i)-(iv) (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account,	F 159		6/12/17

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

Electronically Signed | 05/25/2017

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interest-bearing account, or petty cash fund.

(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

(f)(10)(iii) Accounting and records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(C)The individual financial record must be available to the resident through quarterly statements and upon request.

(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-
(A) When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

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F 159	Continued From page 2 (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on Resident Group Interview, staff interviews and facility documentation the facility staff failed to ensure Residents had access to their personal fund account 7 days a week. The facility staff failed to ensure that Residents had daily access to their patient fund account. The findings included: On 05/10/17 at approximately 10:00 a.m., a group interview was held with 7 residents. During the group interview the residents were asked if they had daily access to their personal fund account. Three out of the seven residents stated they are unable to get money on the weekends; they would go to the front desk and the blind at the front desk would be down. The surveyor informed the residents they are entitled to have access to their personal funds 7 days a week. Locatd in the front lobby was a posting that reads: Resident Banking Hours: Mon. - Fri. (9:00 a.m. - 11:00 a.m.) and Sat & Sun (1:00 p.m. - 3:00 p.m.). Please see secretary at front desk for assistance. Thank you. An interview was conducted with the Business Office Manager on 05/10/17 at approximately 11:25 a.m., who stated "I work Monday - Friday and every other weekend. The resident has access to the funds anytime Monday - Friday	F 159	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 159 1-Residents have daily access to their patient fund account. 2-The Business Office Manager implemented a schedule for business office staff to provide residents daily access to their patient fund account. 3-The Business Office Manager provided education to business office staff on the schedule and office hours to provide residents daily access to their patient fund account. 4-The Business Office Manager or designee will review the as-worked schedule to verify that office hours were provided for residents to access their patient fund accounts on a daily basis.	

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F 159	Continued From page 3 when I'm here and the same for the weekends when I work". The Business Office Manager stated the Manager on Duty (MOD) will issue residents their personal funds on the weekends when she's not here. An Interview was conducted with RN #1 on 5/10/17 at approximately 3:10 p.m., who stated, "I don't have anything to do with issuing money to the residents on the weekends when I'm MOD. I don't have access to their funds; they have to get their money Monday - Friday". On 5/10/17 at approximately 4:45 p.m., an interview was conducted with Discharge Planner who stated when she is MOD her hours varies but will try to get to the facility around 8:00 a.m., and will generally leave between 12 p.m. and 1 p.m. The Discharge Planner stated, "We only have to be at the facility for 4 hours". The surveyor asked if she was aware there was a posting in the front lobby for resident banking hours on Saturday and Sunday between 1:00 p.m. and 3:00 p.m., she replied "No, I didn't realize there were resident banking hours for the weekend". The surveyor then asked, "If you are not here during resident banking hours on the weekend, how are they able to receive personal funds", she replied, "They can't". An interview was conducted with the Business Office Manager on 05/10/17 at approximately 5:05 p.m., The surveyor asked "If the MOD is not here during the residents banking hours, how are the resident able to receive funds between those hours if the MOD has left for the day, she replied "They can't, if the MOD is not here in the facility during the resident baking hours, the residents are unable to receive money from their account".	F 159	The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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F 159	Continued From page 4 The Administrator, DON and Nurse Consultant were informed of the finding during a briefing on 05/11/17 at approximately 12:10 p.m. The facility did not present any further information about the findings. The facility's policy: Banking Hours (Effective Date - 09/01/03). Policy: The patients must have daily access to their patient fund monies. Procedure: The Center will establish "banking hours" to allow patients to have access to their patient funds for at least two hours during regular business working hours, and for a reasonable time on Saturdays and Sundays.	F 159		
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and facility documentation the facility staff failed to put a Foley catheter in a dignity bag for 1 out of 17 residents (Resident #13) in the survey sample. The facility staff failed to put a Foley catheter into a dignity bag.	F 241	F 241 1- Resident # 13 now has a privacy cover attached to the Foley catheter drainage bag. 2- The DON reviewed residents with Foley catheters to ensure that the bag was covered appropriately. 3- The DON or designee provided education to Licensed Nursing staff and	6/12/17

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F 241	Continued From page 5 The findings included: 1. Resident #13 was admitted to the nursing facility on 01/31/16. The diagnoses for Resident #13 included but are not limited to Neuromuscular Dysfunction of the bladder (Neurogenic Bladder) (1). Resident #13 Minimum Data Set (MDS) with an Assessment Reference Date of 02/07/17 coded Resident #13 Brief Interview for Mental Status (BIMS) scoring a 15 out of a possible 15 indicating no cognitive impairment. In addition the MDS coded Resident requiring limited assistance of one with hygiene and bathing. Under section H (Bladder and Bowel) was coded for indwelling catheter (Foley) 2 for use of appliances. During the initial tour on 05/09/15 at approximately 12:00 p.m., Resident #13 was observed in her room sitting up in her wheel chair with her Foley catheter hanging on the right side of her wheel chair. Resident #13's Foley catheter was without a dignity bag (cover). On 05/10/17 at approximately 10:05 a.m., Resident #13 was observed propelling herself in the hallway with her Foley bag hanging on the right side of her wheel chair. The Foley bag was turned with the white side facing outward but was able to see urine from the side. Resident #13 had a blanket trying to cover her Foley bag. An interview was conducted with Resident #13 on 05/10/17 at approximately 2:35 p.m., who expressed concerns that her Foley catheter did not have a dignity cover. Resident #13 stated, "I've had my catheter for over 10 years because	F 241	CNA□s on providing appropriate coverage to Foley catheter drainage bags. 4- The Unit Manager or designee will conduct weekly audits to ensure that resident Foley catheter drainage bags are appropriately covered. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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of my urine problems and I've always had a black bag to put my catheter in until I came to this facility. Resident #13 stated, "Please tell me what I can do to get a black bag". Resident #13 proceeds to say, I use my personal blanket to thrown over my catheter bag so no one can see the urine in my bag. Resident #13 demonstrated how she used her personal blanket to cover up her catheter: Resident removed the catheter from the right side of her wheel chair and stated, "Let me show you how I do this". Resident #13 turned the catheter bag having the white side facing out so you can see the urine, I then take my personal blanket and through it across the arm of the wheel chair covering the catheter bag so you can't see it". Resident stated, if you could get me a black bag to put my catheter in it, I would truly appreciate it, I don't like using my blanket but I don't have a choice.

An interview was conducted with the Unit Manager (Unit C) on 05/10/17 at approximately 3:25 p.m., who stated "We dropped the ball, Resident #13, really should have a dignity bag to put her Foley catheter in".

The Administrator, DON and Nurse Consultant were informed of the finding during a briefing on 05/11/17 at approximately 12:10 p.m. The facility did not present any further information about the findings.

The DON provided the following information for Caring for Persons with Indwelling Catheters on 05/11/17 at approximately 11:25 a.m. (a) when transporting the person in a wheelchair, place the drainage bag in a cover or holder to promote dignity (Mosby's Textbook for Long Term Care Nursing Assistants, Seventh Edition).

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F 241	Continued From page 7 (1) Neuromuscular dysfunction of the bladder (Neurogenic bladder) is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. Several muscles and nerves must work together for the bladder to hold urine until you are ready to empty it. Nerve messages go back and forth between the brain and the muscles that control bladder emptying. If these nerves are damaged by illness or injury, the muscles may not be able to tighten or relax at the right time (https://medlineplus.gov/druginfo/meds/a682514.html). (2) Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html).	F 241		
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		6/12/17

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F 252	Continued From page 8 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide a homelike environment for the residents in one of the two nursing units, Unit C. The findings included: During the initial tour on 5/9/17 at 12:00 pm, 4 residents in wheelchairs were observed in the sitting room watching TV (television). There were various types of equipment stored in the sitting room, such as, a standing/chair scale directly underneath the wall-mounted TV screen, 2 mechanical lifts (1), a folded privacy screen and a large (brand name) positioning and mobility chair. The size of the room was 15 x 18 feet, furnished with sofa and chairs. In the adjacent dining/activity room, there was a lift and a wheelchair stored along the wall right behind the 4 residents who were having lunch at the time. Unfolded lift slings were hanging off the lifts. The dining/activity room was 24 x 16 feet in size. There was a large table at the center of the room that could sit 8 residents and there were some activity supplies stored on one side of the room. On 5/9/17 at 5:55 pm, there was a resident in a	F 252	F 252 1-The equipment was removed from the dining/activity room on 5/10/17. 2-The DON checked the dining/activity rooms for any equipment. 3- The DON or designee will educate facility staff on proper storage of equipment in designated areas and not in the dayroom/activity room. 4- The Unit Manager or Designee will check the dining/activity room on a weekly basis to ensure that there is no equipment stored in this area and is stored appropriately elsewhere. The the results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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wheelchair in the sitting room and 6 residents having dinner in the dining/activity room. There were 2 mechanical lifts, a standing/chair scale, a privacy screen and a large (brand name) positioning and mobility chair stored in the sitting room. There were 3 mechanical lifts stored along the wall of the dining/activity room.

On 5/10/17 at 9:15 am, there was a resident in the sitting room and 3 residents in wheelchairs in the dining/activity room. There were 2 mechanical lifts, a standing/chair scale, a privacy screen and a large (brand name) positioning and mobility chair stored in the sitting room. In the dining/activity room, there were 2 mechanical lifts, a wheelchair and a Geri chair.

On 5/10/17 at 9:20 am, an interview was conducted with Licensed Practical Nurse (LPN) #1 (Unit Manager) in the dining/activity room. She stated that the dining/activity room is used for activities and for residents who did not want to eat in their room nor the large dining room. The sitting/lounge area is used by the residents and also used by the podiatrist (foot doctor) when treating residents, thus the privacy screen stored in the room. When asked if the sitting and dining/activity rooms were used as storage area for the equipment, LPN #1 (Unit Manager) replied, "Yes, we use it as a storage area". She added that there is nowhere else to store them. When asked if she would consider this a homelike environment for the residents, she stated, "Not with these equipment here". When asked if the standing/chair scale could distract the residents watching TV, she stated, "Yes, most definitely a disruption when they're watching TV". She stated that storing the equipment in the dining/activity room would also be considered not

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homelike. When asked how this should be corrected, she stated, "We will place the equipment in a storage area where they are not within the residents' eyesight to make it homelike."

On 5/10/17 at 9:30 am, the Administrator was asked to check the sitting room and the dining/activity room and was asked what made the environment in the rooms not homelike and she stated, "The equipment". On the same day, the rooms were cleared of all the resident care equipment mentioned above. LPN #1 (Unit Manager) offered an inservice training for staff for proper storage of the equipment. A copy of the inservice training record was provided by the facility and documented that 25 staff members had attended the training program. The summary of the training stated, "Mechanical lifts will no longer be stored in the Activity Parlor. They are to be kept in the big shower room".

On 5//10 /17, a copy of the policy and procedure on the provision of homelike environment for the residents was requested and according to the Director of Nursing (DON), the facility did not have a policy.

On 5/11/17 at 12:10 pm, the above findings were shared with the Administrator, DON and Corporate Nurse Consultant and no further information was provided.

(1) Mechanical lift - a patient lift that is used as an assistive device that allows patients in hospitals and nursing homes and people receiving home health care to be transferred between a bed and a chair or other similar resting places. (https://en.wikipedia.org/wiki/Patient_lift)

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F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, 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:	F 309		6/12/17

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F 309	Continued From page 12 Based on staff interviews and clinical record review the facility staff failed to provide the necessary care and services to attain or maintain their highest practical physical well being for 1 of 17 residents in the survey sample, Resident #3. The facility staff failed to follow the physician orders for the management of Resident #3's diabetes. The staff failed to call the physician when the resident's blood sugar was above the set parameter of 401 on eleven (11) occasions from April 12, 2017 through May 6, 2017. The findings included: Resident #3 was admitted to the facility on 4/11/17 with diagnoses to include insulin dependent diabetes, and left diabetic foot infection requiring intravenous (IV)antibiotic therapy. The admission MDS (Minimum Data Set) with an assessment reference date of 4/18/17 coded the resident as scoring a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was moderately impaired. The resident was coded as having received insulin injections for 7 of 7 days of the look back period. The Comprehensive Resident Centered Plan of Care identified as a Focus area the resident's diabetes; refuses blood sugar checks and was non-compliant with diet. The goal was that the resident will have no complications related to the diabetes. One of the interventions listed to achieve and maintain the goal was to administer diabetes medications as ordered by the doctor.	F 309	F 309 1- The physician reviewed the blood sugars for Resident # 3 on 5/11/17 and no changes or recommendations were provided at that time. 2- The DON reviewed residents receiving sliding scale insulin to ensure that the orders were followed appropriately and that the physician was notified when necessary per the physician ordered parameters. 3- The DON educated licensed nursing staff on following sliding scale insulin physician orders and notifying the physician as necessary when above or below set blood sugar parameters. 4- The Unit Manager or Designee will audit blood sugar results on a weekly basis to ensure that sliding scale insulin orders are followed appropriately and that the physician is notified of blood sugar results outside of the ordered parameters. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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The physician orders dated 4/11/17 for the management of the residents diabetes included blood sugar monitoring before meals and at bedtime with an insulin (Novolog) sliding scale order as follows:
If 0-199=0 units
200-250=2 units
251-300=4 units
301-350=6 units
351-400=8 units
401+=10 units and call MD

The Medication Administration Records for April and May 2017 evidenced there were eleven (11) occasions that the residents blood sugar was above the 401+ parameter, the staff administered the 10 units of Novolog but failed to notify the physician as follows:
4/13/17 at 4:00 pm blood sugar=434
4/19/17 at 9:00 pm blood sugar=508
4/23/17 at 11:00 am blood sugar=425
4/26/17 at 4:00 am blood sugar=463
4/27/16 at 11:00 am blood sugar=484
4/28/17 at 11:00 am blood sugar=466
4/29/17 at 4:00 pm blood sugar=477
5/2/17 at 11:00 am blood sugar=434
5/3/17 at 4:00 pm blood sugar=477
5/6/17 at 11:00 am blood sugar=405
5/6/17 at 4:00 pm blood sugar=448

The Director of Nursing (DON) reviewed the April and May MARs, compared them with the physician orders and daily nursing notes and concurred that the facility staff failed to consistently notify the physician when the resident's blood sugar was outside the parameter of 401 as noted above.

On 5/10/17 at 4:25 pm, the attending physician

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F 309	Continued From page 14 was interviewed while inside the DON's office. The above findings was shared. He was asked if he expected the nursing staff to call him when the resident's blood sugar was above 401. He stated, "Yes". When asked why, he stated, "So we can adjust the insulin". On 5/10/17 at 4:30 pm, the Registered Nurse (RN) Unit B manager was interviewed. The above findings was shared. She stated, "They should be calling him, we can call him on his cell phone or home phone...". She stated she was going to educate the nursing staff to follow the physicians orders to call when the residents blood sugar is outside the set parameter. No additional information was provided prior to exit.	F 309		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		6/12/17

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F 315	Continued From page 15 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review and facility document review the facility staff failed to ensure one resident (Resident #7) in the survey sample of 17, with a Foley catheter received the appropriate care and services to prevent complications. The facility staff failed to ensure the indwelling Foley catheter (1) for Resident #7 was anchored to prevent complications such as dislodgement or trauma to the urethra (2). The findings included: Resident #7 was admitted to the facility on 4/7/17 with diagnoses to include Clostridium Difficile infection (C-Diff-an infection of the colon) and two pressure ulcers (3) to the sacrum and right	F 315	F 315 1- The indwelling Foley catheter for Resident # 7 is anchored to prevent complications for the resident. 2-The DON checked residents with indwelling Foley catheters to ensure that the catheter is anchored appropriately. 3- The DON or designee will educate licensed nursing staff on providing an anchor for indwelling Foley catheters. 4- The Unit Manager or Designee will complete weekly observations of residents with indwelling Foley catheters to ensure that they are anchored appropriately. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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buttock.

The admission MDS (Minimum Data Set) with an assessment reference date of 4/15/17 coded the resident as having long and short term memory deficits with moderately impaired daily decision making skills. The resident was assessed as having an indwelling Foley catheter.

The Comprehensive Resident Centered Plan of Care dated 4/12/17 included as a Focus the Foley catheter to promote healing for the unstageable pressure ulcer to the residents sacrum. The goal was that the resident would be free from catheter-related trauma through the next review date. One of the interventions included to monitor/document for pain/discomfort due to catheter and to position catheter bag and tubing below the level of the bladder. The interventions did not include anchoring the Foley catheter tubing.

On 5/9/17 at 5:30 pm, the resident was observed in bed asleep. The Foley catheter was observed attached to the right side of the bed frame inside a dignity bag. The Foley catheter tubing was not anchored.

On 5/10/17 at 10:40 am, a dressing change of the sacral and right buttock pressure ulcer was observed. During the dressing change the resident was repositioned from the right side to the left side and back again to the right side. Each time the resident was repositioned the Foley catheter was observed without slack creating tension on the catheter. The nurse (Licensed Practical Nurse #4) was asked if the Foley catheter should be anchored and stated, "Yes".

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On 5/11/17 at 10:40 am, the above information was shared with the Director of Nursing (DON). The DON stated, "It should be anchored, it's standard of practice...you don't need an order (physician) for one". The DON was asked for a policy for Foley catheter care and stated the facility did not have one that speaks to anchoring the catheter.

The facility provided for review a copy from Mosby's Textbook for Long-Term Care Nursing Assistants 7th Edition. Chapter 21 box 21-3 Caring for Persons With Indwelling Catheters page 362 read, in part:
Secure the catheter to the inner thigh or secure it to the man's abdomen. This prevents excess catheter movement and friction at the insertion site. Secure the catheter with a tube holder, tape, or other devices as the nurse directs.

Anchoring the catheter to the inner thigh reduces pressure on the urethra thus reducing the possibility of tissue injury. Potter and Perry Fundamentals of Nursing 7th Edition chapter 45 Urinary Elimination page 1160.

Medical definitions:

(1) Foley catheter-a tube inserted through the urethra and into the bladder to facilitate urine drainage. Potter and Perry Fundamentals of Nursing 7th Edition.

(2) Urethra-the tube for the discharge of urine extending from the bladder to the outside. Taber's Cyclopedic Medical Dictionary Edition #20.

(3) Pressure ulcer-Damage to the skin or underlying structures as a result of tissue

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F 315	Continued From page 18 compression and inadequate perfusion. Taber's Cyclopedic Medical Dictionary Edition #20.	F 315		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive	F 328		6/12/17

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F 328	Continued From page 19 person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility document review the facility staff failed to ensure one resident (Resident #3) in the survey sample of 17, received the necessary care and specialized services for a central catheter. During the administration of an intermittent intravenous (IV) antibiotic via a PICC (peripherally inserted central catheter (1)) the nurse failed to provide care consistent with professional standards of practice to maintain aseptic technique to prevent the potential for cross contamination. The findings included:	F 328	F 328 1-Resident #3 is receiving appropriate PICC- Line care. 2- No other residents have picc line care at this time. 3- The DON or designee will educate licensed nursing staff on proper care of the PICC line. 4- The Unit Manager or Designee will complete weekly observations of residents with PICC lines to ensure that the appropriate care and technique is followed. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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Resident #3 was admitted to the facility on 4/11/17 with diagnoses to include insulin dependent diabetes, and left diabetic foot infection requiring intravenous (IV) antibiotic therapy.

The admission MDS (Minimum Data Set) with an assessment reference date of 4/18/17 coded the resident as scoring a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was moderately impaired. The resident was coded as having received IV medications while a resident within the last 14 days.

The Comprehensive Resident Centered Plan of Care dated 4/11/17 one Focus area identified the resident had a PICC/Midline catheter for medication administration. The goal was that the resident will have no complications related to (PICC/Midline) infusion therapy through the next review. One of the goals set to achieve or maintain the goal was to administer a flush as ordered by the physician.

The physician orders dated 5/2/17 instructed the staff to administer the antibiotic Piperacillin Sod-Tazobactam solution 4.5 grams intravenously every 6 hours for infection until 5/24/17.

On 5/9/17 at 5:30 pm, a medication administration pass was observed with Registered Nurse #2 (RN). The nurse entered the resident's room, placed the IV antibiotic bag next to the sink, washed her hands and then spiked the IV solution with the new tubing. The nurse then used an alcohol prep pad to wipe one

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of the two PICC line needleless port connectors. After cleansing the cap, the nurse then flushed the PICC line with 10 cc of normal saline, wiped the cap again with an alcohol prep, waited several seconds and then hooked the IV tubing into the capped port. At this time, the nurse turned to this inspector and stated, "I forgot to put on my gloves...do you want me to start over again...". The nurse was told to do what she would normally do, she then programmed the IV pump (electronic infusion device). The nurse then washed her hands and left the room. After leaving the room, the nurse was asked what was the facility policy for donning (putting on) gloves during the preparation of administering an intermittent infusion via a PICC line to include flushing the PICC line ports, she stated she was not sure but would find out. When asked why use gloves for this process, she stated, "As an extra precaution". When asked for who, the staff or the resident, she stated, "The resident".

The above observation was shared with the Administrator, the Director of Nursing and the Corporate Nurse on 5/10/17 during an end of day meeting.

The facility's pharmacy policy titled "3.6 Administration of an Intermittent Infusion" revised 5/1/16 reads, in part:
4. Perform hand hygiene.
6. Don gloves.
8. Using aseptic technique, remove administration set from packaging...
15. Vigorously cleanse needleless connector with alcohol. Allow to air dry.
16. Maintaining asepsis, attach flush syringe to needleless connector...
22. Dispose of used supplies...

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F 328	Continued From page 22 23. Remove gloves. 24. Perform hand hygiene. (1) PICC-A peripherally inserted central catheter (PICC or PIC line), less commonly called a Percutaneous indwelling central catheter, is a form of intravenous access that can be used for a prolonged period of time (e.g., for long chemotherapy regimens, extended antibiotic therapy, or total parenteral nutrition).	F 328		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 371		6/12/17

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F 371	Continued From page 23 This REQUIREMENT is not met as evidenced by: The facility staff failed to store, prepare and serve food in accordance with professional standards for food service safety. The chemical sanitizing solution concentration inside the sanitizer bucket was not maintained at the appropriate concentration according to manufacturers recommendations. The findings included: An inspection of the kitchen was conducted on 5/9/17 at 12:00 pm. The Certified Dietary Manager (CDM) escorted this inspector. Stored on top of the three compartment sink was a sanitary bucket containing one cleaning cloth inside of it. The CDM was asked to test the solution. The chemical strip indicated the concentration was 100 ppm (parts per million). The CDM stated the concentration should be 200 ppm. She further stated it was the cooks responsibility to empty and refill the sanitizing bucket prior to breakfast, after lunch and after dinner. The CDM stated the solution is used to "wipe down table tops, carts, tray carts, outside of the cooler, everything...". On 5/11/17 at 10:18 am, the Registered Dietician (RD) and the CDM provided additional information. The RD stated that she does monthly kitchen checks and the sanitizing solution had always been correct, she stated this was an "isolated thing". A copy of the Sanitizer Concentration Log for May 2017 was provided for review. The log indicated the solution was checked three times a day and was at 200 ppm's each check.	F 371	F 371 1- The chemical sanitizing solution concentration is maintained at the appropriate concentration. 2- The sanitizing solution was checked by the Dietary Manager to ensure that the concentration was at 200 ppm. 3- The Dietary manager or designee will provide education to Dietary staff on the appropriate procedure to follow in checking the chemical sanitizing solution concentration inside the sanitizing bucket. 4- The Dietary manager or designee will complete weekly audits to ensure that the sanitizing solution concentration is checked per policy and maintained at the appropriate ppm. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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F 371	Continued From page 24 The facility's Dining Services policy titled "Sanitation" dated 4/27/16 read, in part: Policy-Routine cleaning will be done to maintain a sanitary work environment. A cleaning schedule will be posted in the department. 7. Sanitizing buckets will be emptied and refilled at least three (3) times a day, and sanitizing solution concentration will be checked and recorded three (3) times per day and recorded on the Sanitizer Concentration Log. The manufacturer's label on the disinfectant sanitizer read, in part: To sanitize pre-cleaned immobile food processing equipment and surfaces (tanks, finished wood or plastic chopping blocks, counter tops, conveyors) flood the area with a 200-400 ppm active quaternary solution for at least 60 seconds.... The above findings was shared with the Administrator, the Director of Nursing and the Corporate Nurse during an end of day meeting on 5/10/17.	F 371		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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	F 431		6/12/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 25	F 431		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	05/11/2017

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F 431	Continued From page 26 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to ensure one medication cart was secure for one of two units, Unit C, and failed to date an opened multidose vial of influenza vaccine on 1 of 2 units (Unit 1). 1. The facility staff failed to ensure medication cart was locked when not in direct sight on Unit C. 2. The facility staff failed to date an opened multidose vial of influenza vaccine. The findings include: On 05/10/17 at approximately 8:45 a.m., LPN #1 went into room #14, closing the door behind her to administer medication without locking the medication cart. When LPN #1 returned to the medication cart, the surveyor asked LPN #1, if she was aware that she had left the medication cart unlocked, she replied "Yes, I should have locked it". On 05/10/17 at approximately 9:05 a.m., the Unit Manager of Unit C was made aware that LPN #1 had left her medication cart unlocked when not in her direct supervision. The Unit Manager replied, "The medication cart should be locked when not in sight by the nurse, even if she turns her back it must to be locked". An interview was conducted with the Director of Nursing (DON) on 05/10/17 at approximately at	F 431	F 431 1- Medication carts are locked and secured. The Influenza vaccine was wasted on 5/9/17. 2- The DON checked the Medication carts to ensure that they are locked and secured. The DON checked the Medication room refrigerators to ensure that there are free from undated medications and biologicals. 3- The DON educated Licensed nursing staff on locking and securing medication carts and the protocol for dating opened medications and biologicals. 4- The Unit Manager or designee will complete weekly audits of the medication room refrigerator to ensure that opened medications and biologicals are dated appropriately. The Unit Manager or designee will complete weekly observations to ensure that the medication carts are locked and secured appropriately. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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11:55 p.m. The DON was asked, "What is your expectation for your nurses when the medication cart is not in their direct view", she replied, "The medication cart must be locked when it's not in direct sight".

The above information was shared with the Administrator and DON during a pre-exit meeting on 05/11/17 at approximately 12:10 p.m. No additional information was provided.

The facility's policy: "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" (Last Revision Date: 10/31/16).

3. General Storage Procedures: 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.

2. The facility staff failed to date an opened multi-dose vial of Influenza vaccine stored inside one of two medication rooms.

An inspection of the Unit B medication storage room was conducted on 5/9/17 at 1:50 pm. Stored inside the locked medication refrigerator were multiple dose vials of biologicals to include Influenza vaccine vials. One opened multi-dose 5 ml (milliliter) Influenza vaccine vial was found. This vial was not dated when opened.

The licensed practical nurse (LPN#2) who opened the locked medication room was questioned about the dating of this vial and asked once opened how long was it good for. Her response was that the vial should have been

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dated once opened, and that the vial was good for 90 days.

On 5/10/17 at 4:00 pm, the Unit B, Registered Nurse manager was interviewed. The above findings was shared. She stated, "They know when they pop a top they need to date it". She stated once opened the Influenza vaccine was good for 28 days.

The manufacturer's insert package for the Influenza vaccine read, in part:
Storage and Handling- Once the stopper of the multi-dose vial has been pierced the vial must be discarded within 28 days.

The facility's policy titled 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles revised 10/31/16 read, in part:
5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.

The above findings was shared with the Administrator, the Director of Nursing and the Corporate Nurse during and end of day meeting on 5/10/17.