STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	R-C 01/18/2017

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 12/6/16 through 12/8/16, was conducted 1/17/17 through 1/18/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 120 certified bed facility was 100 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 101 through 113) and 0 closed record reviews.	{F 000}		
{F 241} SS=D	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, staff interview, and clinical record review, the facility staff failed to provide a dignified living experience for one Resident (Resident #109) in a survey sample of 13 Residents. For Resident #109, CNA (certified nursing assistant) A was observed sitting on Resident #109's bed, eating her lunch utilizing his overbed table to hold her lunch, and watching his television. Resident #109 was out of his room and sitting in the unit's common television room.	{F 241}	F 241 SS=D 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY With regard to this deficient practice, the facility has taken the following actions: A. C.N.A.-A was counseled and received a written disciplinary action write-up. Future violations of facility policy will result in termination. B. The facility has identified all residents as having the potential through a 100%	1/27/17

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

Electronically Signed | 01/27/2017

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{F 241}	Continued From page 1 The findings included: The initial tour of the facility began 1/17/17 at 1:48 p.m. Resident #109's bedroom door was noted to be closed at 2:04 p.m. After knocking and announcing the surveyor presence, the bedroom door was opened. CNA A was observed sitting on the side of Resident #109's bed with a foam tray container in front of her on the over bed table. CNA A appeared to be watching the television. Resident #109 or his roommate were in the bedroom. Resident #109 was later observed sitting in the unit common television room. CNA A stated she had finished her lunch and closed the container. CNA A did not rise from the bed nor leave Resident #109's bedroom. LPN (licensed practical nurse) A stated 1/17/17 at 2:15 p.m., CNA A was assigned to assist Resident #109, 1/17/17. CNA A was interviewed 1/18/17 at 8:50 a.m. CNA A stated she was unaware that she should not be sitting on Resident #109's bed, eating her lunch in his bedroom, nor watching his television. CNA A stated she had been employed at the facility for four months. CNA A stated the DON (director of nursing) had discussed her actions in Resident #109's bedroom on 1/17/17. "They wrote me up..." according to CNA A. LPN A stated she had entered Resident #109's bedroom shortly after being interviewed 1/17/17. LPN A said CNA A was still sitting on Resident #109's bed and watching television when LPN A entered the bedroom. LPN A stated she told CNA A that her actions were not appropriate. LPN A stated CNA A should have eaten lunch and taken	{F 241}	audit to assure that all residents are provided a dignified living experience in resident rooms with corrections when indicated. C. Measures put in place include additional staff training regarding providing a dignified living experience and not using residents rooms for personal use to all clinical staff members by the Director of Nursing on>>>>>>>>>>. The DON or delegate is completing resident rounds 5 x weekly on varying shifts to ensure compliance. Corrective action is implemented immediately with additional one-on-one in-service with the staff member. D. The results will be reported in the weekly Risk Committee Meeting and Quarterly in the Nursing Home Quality Improvement Committee Quarterly by the Director of Nursing. Reports of the findings from the audits, along with disciplinary action, if applicable, will be reported to the Director of Nursing and to the Quality Assurance Committee consisting of the Director of Nursing, Medical Director, NHA, Pharmacy Consultant, Social Services, Risk/Wound Nurse, Physical Therapy Director and the Director of Dietary on a monthly basis. Any trends or patterns identified will be addressed and corrective action plan revised if indicated.	

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{F 241}	Continued From page 2	{F 241}		

her break in the staff lounge.

The DON stated 1/18/17 at 11:55 A.M. she had disciplined CNA A for her actions in Resident #109's bed room.

"Fundamentals of Nursing, 7 th Edition, Potter-Perry, p. 475," provides guidance, "A sense of dignity includes a person's positive self-regard, an ability to invest in and gain strength from one's own meaning in life, feeling valued by others, and how one is treated by caregivers. Nurses promote a client's self esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience...When caring for a client's bodily functions, show patience and respect, especially after the client becomes dependent."

Resident #109, a male, was initially admitted to the facility 3/8/13 and readmitted after a hospitalization 2/26/15. His diagnoses included benign prostatic hypertrophy, obesity, unspecified psychosis, cerebral palsy, cardiomegaly, severe intellectual disability, aphasia, lack of coordination, and hypertension.

Resident #109's most recent MDS (minimum data set) with an ARD (assessment reference data) of 11/7/16 was coded as a quarterly assessment. Resident #109 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. He was also coded as requiring total assistance of one to two staff members to perform his activities of daily living with the exception of eating. For eating, he was coded as needing limited assistance of one staff member.

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{F 241}	Continued From page 3 The administrator and DON were informed of CNA A not fostering a dignified living experience for Resident #109 by sitting on his bed, eating her lunch, and watching television 1/18/17 at 11:55 p.m.	{F 241}		
{F 278} SS=C	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	{F 278}		1/27/17

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{F 278}	Continued From page 4 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident Assessment Instrument) for one Resident (Resident #113) in a survey sample of 13 Residents. For Resident #113, her height was coded as "0" inches. The findings included: Resident #113, a female, was admitted to the facility 2/22/13. Her diagnoses included diffuse osteoarthritis, Parkinson's, unspecified dementia without behavioral disturbances, hypertension, ataxia, hypercholesterolemia, gastroesophageal reflux disease, hypothyroidism, chronic obstructive pulmonary disease, dyspnea and dysphagia. Resident #113's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/17 was coded as an annual assessment. Resident #113 was coded as having short and long term memory deficits and required total assistance of one to two staff members to perform her activities of daily living. Resident #113 was coded as being "0" inches tall and weighed 128 pounds. Review of Resident #113's height revealed	{F 278}	F 278 SS=C 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: a. Resident #113 MDS was corrected to include height Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: a. All residents have the potential to be affected by deficient practice. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: a. MDS Director/ DON inserviced Dietary Manager on the accuracy of MDS coding including height in section k. Monitoring of corrective action to ensure the deficient practice will not reoccur:	

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{F 278}	Continued From page 5 documentation within her clinical record that she was 62 inches tall. When interviewed LPN (licensed practical nurse) C, an MDS coordinator, stated 1/18/17 at 9:28 a.m., the dietary manager was responsible for completing Section K "Swallowing and Nutritional Status. Other A, the dietary manager, stated 1/18/17 at 10:10 a.m., she thought she had entered Resident #113's height when she completed her portion of the MDS. Other A stated she did not know if the miscoding was a "computer glitch..." Guidance for coding height in "Long Term Care Facility Resident Assessment Instrument User's Guide 3.0, V 1.13, October 2016, p. K-2: "A. Height (in inches). Record the most recent height measure since the most recent admission/entry or reentry." The administrator and DON (director of nursing) were informed of the failure of the staff to complete an accurate MDS RAI assessment including height for Resident #113, 1/18/17 at 11:55 a.m.	{F 278}	a. Bi-monthly audits of MDS section k swallowing and nutritional status will be completed by the Director of Nursing or designee to ensure proper coding of section k on the MDS. b. Reports of the findings from the audits will be reported by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, and MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis for three months. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	
{F 333} SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors.	{F 333}		1/27/17

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{F 333}	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure one Resident (Resident #113) in a survey sample of 13 Residents was free from significant medication error. The facility staff crushed Potassium ER (extended release) 20 meq (milliequivalent) and administered the medication to Resident #113 in a crushed form two out of six days. Potassium ER is an extended release medication and is not to be crushed. The findings included: Resident #113, a female, was admitted to the facility 2/22/13. Her diagnoses included diffuse osteoarthritis, Parkinson's, unspecified dementia without behavioral disturbances, hypertension, ataxia, hypercholesterolemia, gastroesophageal reflux disease, hypothyroidism, chronic obstructive pulmonary disease, dyspnea, and dysphagia. Resident #113's most recent Minimum Data Set with an Assessment Reference Date of 1/13/17 was coded as an annual assessment. Resident #113 was coded as having short and long term memory deficits and required total assistance of one to two staff members to perform her activities of daily living. Resident #113 was observed 1/17/17 at 3:07 p.m. She was lying back in a speciality chair in her bedroom. Resident #113 was alert however nonverbal. Her feet were elevated on two pillows.	{F 333}	F-333 D 483.45 (f)(2) 1. Corrective action(s) accomplished for those residents found to have been affected by the practice include: A. LPN-F was educated that K-Tabs (Potassium) were to be swallowed whole and that all medications were to be administered in accordance with physician orders. B. The Potassium for resident #113 was changed to a liquid form to allow ease of swallowing while administering medications in accordance with physician□s orders. 2. How will the facility identify other residents who have the potential to be affected by the deficient practice: The facility has identified that all residents who receive Potassium have the potential to be affected by this deficient practice. A. A 100% audit of all residents who receive potassium was conducted to ensure medications were not being crushed and administered in a manner that is free from significant medication errors 3. Measures/systematic changes put in place to ensure this deficient practice does not reoccur include: A. Licensed nurses were in serviced by DON/Designee on administering medications in accordance with physician orders, and medications that were not to be crushed or broken prior to administration. B. Medications identified as those to not	

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{F 333}	Continued From page 7 Resident #113 was also observed 1/18/17 at 8:59 a.m. She was receiving daily care from the CNA (certified nursing assistant). Review of Resident #113's clinical record revealed a signed physician's order that included, "2/21/13 POT (potassium) CL (chloride) MICRO TAB 20 MEQ (milliequivalent) ER ONE TABLET BY MOUTH EVERY MORNING-POTASSIUM SUPPLEMENT-DO NOT CRUSH." An additional order was evident "3/21/14 MAY CRUSH MEDS." Accompanying entrys were noted on the MAR (medication administration record) for the administration of Potassium Chloride 20 meq ER and the guidance to the staff that Resident #113's medications may be crushed. Nurses' initials were evident that Potassium Chloride 20 meq ER was administered daily between 1/13/17 and 1/18/17 by two different nurses, LPN (licensed practical nurse) E and LPN F. LPN E documented she had administered the medication on 1/13, 1/14, 1/16, and 1/17/17. LPN F documented she had administered the medication on 1/15/17 and 1/18/17. A valid physician's order for the administration of Potassium Chloride 20 meq ER and guidance that Resident #113's medications may be crushed were evident on the most recently signed "Physician's Order" sheet signed by the physician on 1/1/17. When interviewed regarding how Resident #113 was administered her medications, LPN F said 1/18/17 at 9:25 a.m., she crushed all of Resident #113's medications. LPN F said Resident #113 was unable to swallow her medications whole.	{F 333}	crush/break were provided from pharmacy, and placed on a list in front of the medication administration record. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. DON Designee will observe medication administration 1 x week x 4 weeks then monthly x 3 months to ensure medications are administered as ordered and without medication errors. B. Reports of the findings from the audits will be reported by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, and MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis for four (4) months. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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{F 333}	Continued From page 8	{F 333}		

LPN F showed the packet of prepackaged medications and stated she poured the medications from the packet into the sleeve used to crushed the medications. LPN F said she thought a liquid form of Potassium could be ordered as the Potassium Chloride should not be crushed.

LPN E stated 1/18/17 at 9:50 a.m. she did not crush Resident #113's potassium. LPN E said the medication should not be crushed, so she would break the tablet in half. The medication was then put in applesauce to soften and "It takes some time" but ultimately Resident #113 would swallow the medication.

Review of the facility's policy entitled "Administering Medications" included:

"3. Medications must be administered in accordance with the orders, including any required time frame.

6. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication."

Guidance was provided at www.dailymed.nlm.nih.gov:

"BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH CONTROLLED-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR

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{F 333}	Continued From page 9 EFFERVESCENT POTASSIUM PREPARATIONS, OR FOR PATIENTS WITH WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS. K-TAB tablets should be taken with meals and with a glass of water or other liquid. This product should not be taken on an empty stomach because of its potential for gastric irritation (see WARNINGS). NOTE: K-TAB tablets are to be swallowed whole without crushing, chewing or sucking the tablets." The administrator and DON (director of nursing) were informed of the failure of LPN F to administer Potassium Chloride 20 meq ER per physician's order, without crushing, 1/18/17 at 11:05 a.m.	{F 333}		
{F 441} SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	{F 441}		1/27/17

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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.

(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,

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{F 441}	Continued From page 11 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, facility documentation review, and clinical record review, the infection control committee failed to implement an effective infection control program for one Resident (Resident #110) in a survey sample of 13 Residents. The tubing and face mask for Resident #110's c-pap (continuous positive airway pressure) machine was observed on the floor in her bedroom on 1/17/17 at 2:04 p.m. 3:10 p.m., and 4:18 p.m. www.nhlbi.nih.gov identified a c-pap machine as, "CPAP is a treatment that uses mild air pressure to keep your breathing airways open. It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea." The findings included: Resident #110, a female, was admitted to the facility 9/12/16. Her diagnoses included coronary artery disease, type II diabetes mellitus, glaucoma, depression, sleep apnea, hypertension, and idiopathic gout.	{F 441}	F 441 SS=D 483.80 (1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS With regard to this alleged deficient practice, the facility has taken the following action: The facility has identified all residents as having the potential to be affected by this alleged deficient practice. A. Resident #110 tubing and face mark is sanitized and bagged when not in use. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: All resident rooms have the potential to be affected by the deficient practice. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Managers have been assigned Angel rounds to inspect resident rooms and all other resident areas to ensure a safe, clean, comfortable homelike environment to include the bagging of masks not in use	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	R-C 01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 441}	Continued From page 12 Resident #110's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/14/16 was coded as a quarterly assessment. Resident #110 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #110 was coded as requiring total assistance of two staff members to perform her activities of daily living with the exception of eating. For eating, she was coded as requiring set up assistance. Resident #110's bedroom was observed during initial tour of the facility 1/17/17 at 2:04 p.m. She was not in her bedroom. On her bedside table, a machine (later identified as a c-pap machine) was noted with white tubing coming from the machine down to the floor. At the end of the tubing was observed a face mask that was observed sitting directly on the floor. The bedroom, with the c-pap machine in the same position, was observed at 3:10 p.m. and 4:18 p.m. on 1/17/17. LPN (licensed practical nurse) A, the nurse caring for Resident #110, stated 1/18/17 at 8:55 a.m., the tubing and face mask should be stored in a plastic bag. She also stated the tubing and face mask should not be on the floor. Guidance was provided for the care of a CPAP machine at www.dailymd.com, "For best results, keep the machine clean." Guidance is provided in "Fundamentals of Nursing 7th Edition, p. 652, Use your critical thinking skills to prevent an infection from developing or spreading. Implement procedures to minimize the numbers and kinds of organisms that could be possibly transmitted. Eliminating reservoirs of infection, controlling portals of exit	{F 441}	Monitoring of the corrective action to ensure this alleged deficient practice does not recur includes: Reports of the findings from the audits will be reported to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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{F 441}	Continued From page 13	{F 441}		

and entry, and avoiding actions that transmit microorganisms prevent bacteria from finding a new site to grow. Proper use of sterile supplies, barrier precautions, standard precautions, transmission -based precautions and proper hand hygiene are examples of methods to control the spread of microorganisms."

www.medscape.com included:

"To minimize the risk of infection, a program in LTCF (Long Term Care Facilities) should attempt to reduce the potential of aspiration, minimize atelectasis and provide care for respiratory therapy equipment."
Review of the facility's policy entitled "Infection Control" included:
"Policy
The primary purposes of this facility's infection control policy and procedure are to establish guidelines to follow to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
2. The objectives of our infection control policies and procedures are to:
b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public;"
The administrator and DON (director of nursing) were informed of the failure of the staff to implement an effective infection control program by ensuring Resident #110's CPAP tubing and face mask were not on the floor, 1/18/17 at 11:05 a.m.