STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 3/14-16/2017. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Life Safety Code survey/report will follow. The census in this 130 bed certified facility was 126 at the time of the survey. The survey sample consisted of 21 resident reviews (Residents 1-21) and 3 closed record reviews (Residents 22-24)	F 000	Preparation and submission of this plan of correction does not constitute an admission, or agreement by the provider, of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of the correction is prepared and submitted solely because of the requirements under State and Federal law.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157	1. Physician was notified that resident #10 had 15 finger sticks that were greater than 400. Resident received a new order to obtain HgbA1c and to increase his Lantus to 24units daily. 2. Residents with a diagnosis of diabetes and receive insulin with parameters have the potential to be affected. RECEIVED APR 10 2017 VDH/OLC	04/18/2017

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

Administrator 04/07/2017

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 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility documentation review, hospital documentation review and clinical record review, the facility staff failed to inform the physician of a change in condition for one Resident (Resident #10) in a survey sample of 24 Residents. For Resident #10, the physician was not informed of 15 finger stick blood sugar (FSBS) readings greater than 400, per physician's order. The findings included:	F 157	3. An audit will be completed on residents who receive insulin with blood glucose parameters. These residents' orders will be updated with new standing orders to alert nurses to check for parameters prior to administrating insulin. The nursing staff will receive education on effective insulin management. If current order is not controlling blood glucose, license nurse will notify MD. Licensed nursing staff will be in-serviced when entering new insulin orders with parameters to choose the new batch order for insulin, which allows parameters to be entered. This will alert nursing staff to check parameters before administering insulin. Licensed staff will complete medication administration quiz to validate competency.	

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F 157	Continued From page 2 Resident #10 was admitted to the facility initially on 8/25/16 and was readmitted after a hospitalization on 1/9/17. Diagnoses included glaucoma, diabetes, hypertension, dementia and seizure disorder. Resident #10 was observed in his room on 3/14/17 at 4:30 p.m. He was in his bed covered with a Redskins blanket and wearing a hospital gown. Resident #10 was talkative regarding his stay in the facility. Resident #10 said he did not want to live in the facility, that he was bored and that he had spoken with the staff regarding finding another place to live, a place that was closer to northern Virginia. Resident #10 acknowledged he was receiving insulin injections and he said he could learn to give himself injections. A review of Resident #10's hospital documentation and facility clinical record was initiated on 3/15/17 at 8:30 a.m. A quarterly MDS (minimum data assessment) with an ARD (assessment reference date) of 1/20/17 coded Resident #10 a BIMS (brief interview of mental status) score of "15" out of 15, cognitively intact. Resident #10 was coded as needing staff supervision only with ADLs (activities of daily living). Diabetes was coded as an Active Diagnosis. Resident #10's comprehensive care plan included a plan for Risk for Metabolic Complications r/t (related to) diabetes. Interventions included, "1. Medications as ordered. 2. Notify MD (medical doctor) as indicated. 3. Blood Glucose levels as ordered ".	F 157	4. The Director of Clinical Services/ assigned designee will audit random blood glucose levels 4xs a week for 30 days, then 2xs a week for 30 days to determine if current order is effective diabetic management and MD is notified when indicated. SDC will complete random observation of insulin administration 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	

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Review of Resident #10's hospital documentation from 1/7/17 through 1/9/17 revealed he was admitted with a diagnosis of Diabetic Ketoacidosis (DKA). His blood sugar measurement on admission to the hospital was 466. (Reference Ranges - "Before a meal: 80-130 and 1-2 hours after beginning of the meal, less than 180." www.diabetes.org)

"DKA is an acute complication of diabetes mellitus characterized by hyperglycemia.." Lippincott's Manual of Nursing Practice, 8th edition, p. 928.
"When your cells don't get the glucose they need for energy, your body begins to burn fat for energy, which produces ketones..... When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump to use glucose. When ketones build up in the blood, they make it more acidic. They are a warning sign that your diabetes is out of control or that you are getting sick." www.diabetes.org

On 1/10/17, after readmission to the facility, the physician wrote an insulin order which read, "Humalog Solution 100 unit/ml (milliliter) Inject 5 unit subcutaneously before meals related to Type 2 Diabetes. Hold if blood sugar is less than 100. Contact MD if less than 60 or greater than 400".

Review of the January 2017 MAR (medication administration record) revealed finger stick blood sugar (FSBS) results that were greater than 400 on 1/11 at 5 p.m. (481); 1/12 at 5 p.m. (566); 1/17 at 5 p.m. (576); 1/18 at 5 p.m. (506); 1/20 at 5 p.m. (491); 1/21 at 5 p.m.(466); 1/22 at 12 p.m. (479) and 5 p.m. (491); 1/23 at 5 p.m. (583); 1/24 at 5 p.m. (412); 1/26 at 5 p.m. (488).
Review of the February 2017 MAR revealed

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FSBS results that were greater than 400 on 2/10 at 5 p.m. (498) and 2/14 at 12 p.m. (461) and 5 p.m. (411).

A thorough review of the clinical record did not reveal physician notification of the blood sugars in question.

On 3/15/17 at 3:30 p.m., during an end of day briefing, the administrator and the DON (director of nursing) were informed of the FSBS measurements greater than 400 and without physician notification. The DON said she would follow-up.

On 3/16/17 at 9:50 a.m., a follow-up interview with the DON regarding the FSBS measurements in question was conducted. The DON said the order was not for sliding scale insulin and therefore the nurse didn't expect to see parameters in place for physician notification. The DON stated, "They (the nurses) didn't look at the summary tab to read the entire order." The DON said the expectation was for the nurses to follow the physician's order for notification.

On 3/16/17 at 10:10 a.m., unit nurse LPN (licensed practical nurse) D was interviewed as she opened the lap top computer to Resident # 10's MAR. LPN D stated," If you hit the 'MORE' tab, the entire physician order is visible." The entire order on the eMAR (electronic medication administration record) included , "Contact MD if less than 60 or greater than 400".

On 3/16/17 at 10:15 a.m., the unit manager, LPN C was interviewed. LPN C said she had reviewed Resident #10's clinical record and found no evidence of physician notification of the blood

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F 157	Continued From page 5 sugar measurements that were greater than 400. The facility's Insulin Administration policy was reviewed and did not include directions regarding parameters or physician notification. Guidance for nursing practice for the administration of medications was included in, Mosby's Potter and Perry, "Fundamentals of Nursing 7th Edition, p. 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." On 3/16/17 at 3:00 p.m., the administration was informed of the staff's failure to notify the physician of blood sugar measurements greater than 400, per the physician's order. There was no additional information provided.	F 157		
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 223	1. Resident #15 was assessed by physician after being informed that she was "sexually assaulted" by resident #2. No trauma, no bleeding or swelling noted. Social Service will follow the resident for psychosocial support weekly or as needed. Facility submitted a Facility Reported Incident form to OLC of Virginia and all appropriate agencies. CNA E was educated on the proper procedure for resident to resident abuse includes: separate and protect resident immediately.	04/18/2017

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F 223	Continued From page 6 documentation review and clinical record review, the facility staff failed to protect one Resident (Residents #15) in a survey sample of 24 residents from another resident (Resident #2) after a sexual assault. Resident #15 was sexually assaulted by Resident #2. The facility staff failed to immediately separate and protect Resident #15 from Resident #2 after becoming aware of the assault. The findings included: Resident #15 was admitted to the facility 12/20/13. Her diagnoses included non-Alzheimer's dementia and hypertension. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/12/17 was coded as a quarterly assessment. Resident #15 was coded a BIMS (brief interview of mental status) score of 5, severe impairment. She was coded as needing extensive to total assistance of one staff member to perform her activities of daily living, except for eating. For eating she required limited assistance by staff. Resident #15 was incontinent of bowel and bladder. Resident #15 had no range of motion limitations and her primary mode of mobility was her wheelchair. Resident #15 was coded for no behaviors and no wandering. Resident #2 was admitted to the facility on 5/4/16 and readmitted from the hospital on 9/28/16. Her diagnoses included hypertension, hemiplegia and hemiparesis following a stroke affecting her left non-dominant side, diabetes and major depressive disorder.	F 223	2. Any resident that encounters a resident to resident altercation has the potential to be affected. 3. The facility staff will be re-educated on company's abuse policy. Facility staff will complete quiz on abuse to validate understanding of policy and procedure. 4. The DCS/designee will conduct random audits with facility staff on the proper procedure for abuse 4xs a week for 30days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/17	

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Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/3/17 was coded as a quarterly assessment. Resident #2 was coded a BIMS (brief interview of mental status) of 11, moderate cognitive impairment. She was coded as needing limited to total assistance of one staff member to perform her activities of daily living except for eating. For eating she required limited supervision by staff. Resident #2 was incontinent of bowel and bladder. Resident #2 had range of motion limitation on one side and her primary mode of mobility was her wheelchair. Resident #2 was coded for no behaviors and no wandering.

On 3/14/16 at 2:30 p.m., Resident #2 was observed in her room in her bed. She was watching a maintenance staff member as he repaired the air conditioner in her room. Resident #2 was very talkative and denied having any concerns or discomfort. Resident #2's bed was beside the window and she shared a room with Resident #15, whose bed was perpendicular to her bed and located near the door.

On 3/14/16 at 3:00 p.m. Resident #15 was observed sitting in the dining room area in her wheelchair where she was staring out of large glass window. Resident #2 was appropriately dressed and responded quietly, though confused at times, to conversation.

On 3/15/16 at approximately 10:00 a.m., the administrator announced to the survey team that Resident #15 sexually fondled Resident #2 and that Resident #15 was being sent to the emergency room for evaluation. The

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administrator said the plan was to separate the residents and send a Facility Reported Incident (FRI) to the Office of Licensure and Certification. At the time of this announcement, there was a police officer in the facility addressing the incident. The administrator said Resident #15 would most likely be the one to change rooms because there were no private rooms available. The administrator said Resident #2 would be staying in the same room without a roommate.

On 3/15/16 at 10:30 AM, a review of Resident #15 and Resident #2's clinical record was initiated and the review revealed the following:
a. Resident #2's progress note dated 3/15/17 at 6:27 a.m., "MD (medical doctor) and PT (patient) OWN RP (responsible party) MADE AWARE OF PT FONDLING ANOTHER RESIDENT. At 9:56 a.m. a note read, "MD examined resident and found no injuries, gave new orders to send res. to ER for evaluation r/t (related to) earlier inappropriate incident with roommate. At 10:25 p.m. a note read, "Report from hospital, reports resident is on Antibiotic for UTI (urinary tract infection). Upon arrival, began on 1:1 supervision at all times."

b. Resident #15's progress note dated 3/15/17 at 6:29 a.m., "..Resident was found being fondled by another resident." At 9:47 a.m., "PATIENT WAS EXAMINED THIS AM AFTER STAFF MEMBER REPORTED INAPPROPRIATENESS. PATIENT HAS NO NOTED VAGINAL TRAUMA-NO SWELLING OR BLOOD COMING FROM VAGINAL AREA. PATIENTS BRIEF WAS CHANGED AND PERICARE COMPLETED-NO DISCHAREGE NOR BLOOD WAS NOTED." Author: Physician, Emp. Q

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c. A Facility Reported Incident dated 3/15/17 was coded as a Resident to Resident incident described the incident and action taken: "It was reported that nursing staff observed [Resident #2's name] was @ her roommate [Resident #15's name] bedside and her hand was@ [Resident #15's name] private area. Two patients were separated immediately. [Resident #2's name] was placed on one on one supervised." Signed by the Administrator and faxed to the OLC at 10:09 a.m.

On 3/15/16 at 2:00 p.m., a request was made to the administrator and the DON (director of nursing) to interview the staff member that initially witnessed the incident. The DON said CNA (certified nursing assistant) E witnessed the incident and she worked on the night shift.

On 3/16/16 at 8:15 a.m., the administrator and the DON were asked again to arrange an opportunity for an interview with CNA E.

On 3/16/16 at 11:00 a.m., a telephone interview was conducted with CNA E. When asked what happened when she saw the two residents, CNA E stated, "I was doing rounds, passing ice, when I saw Resident #2 sitting at the foot of Resident #15's bed with her hand down in Resident #15's brief." When asked what she did after that, CNA E stated, "I told Resident #15 to not move, stay right there, and I went down the hallway to the nurse's station to get two other nurses." CNA E said she wanted the nurses to witness what she saw. CNA E said after she and the two other nurses, returned to the room, Resident #15 was in the same position and Resident #2 was in and out of sleep. CNA E stated, "She (Resident #15) is hard to wake up, she is a heavy sleeper." CNA

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E said she and the other nurses separated the residents and the nurse examined Resident #15. CNA E said, "She (Resident #2) said she thought her roommate (Resident #15) was a man." When asked how long she left the residents alone after she identified the incident, CNA E stated, "Oh not long, I am tall and I have long legs."

A review of the facility floor plan displayed the hallway in which Resident #2 and Resident #15 resided. There were eight resident room between their room and the nurse's station.

On 3/16/16 at 11:30 a.m., the administrator provided copies of the staff Witness Statements dated 3/15/17 which read as follows:
a. CNA E wrote, "I notice the resident (Resident #2) from bed B sitting on the foot of[Resident #15's name] I went immediately to tell the nurses LPN (licensed practical nurse) E and LPN F and they both came down to the room."

b. LPN E wrote, "CNA E came to the nurse's station to report to the charge nurse, LPN F and myself, LPN E, night supervisor that [Resident #2's name] was sitting on her roommates bed with her hand inside her brief. "

c. LPN F wrote, "CNA notified nurse to come to residents room. [Resident #2] was sitting on [Resident 315's name] bed with brief area moving open fingers were in [Resident #15's] groin area moving hand. [Resident #2's name] states [Resident #15] was a man and [Resident #15's name] was not compl. (sic) Resident #2 made to wash hands and Resident #15's skin checked. Resident #2 placed at nurses station until 6 am then placed in room for 1:1 with nurse till day shift arrived."

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At approximately 11:20 a.m., Resident #15 was observed in a different room, it was the room directly next door to her prior room. Resident #15 was now in a bed beside the window and she was seated in her wheelchair looking out her bedroom window. Her affect was pleasant and she answered, "Yes" when asked if she liked her new room.

At 11:30 a.m., the unit manager, RN A, was interviewed and said Resident #2 was transferred to the emergency room earlier that morning due to a change in her mental status.

On 3/16/17 at 12:00 p.m., the interview with CNA E and the review of the witness statements were shared with the administrative staff. All evidence indicated that Resident #15 was left alone with Resident #2 when a staff member witnessed an occurring sexual assault. Based on the assessment of Resident #15's cognitive status, Resident #15 was not cognitively able to consent to a sexual interaction with Resident #2. When asked what was the facility's expectation regarding this sexual incident between these two residents and the corporate nurse, Emp C, said the incident should have been treated just like any Resident-to-Resident incident and added, "Immediately separate the residents and keep the resident safe."

A review of the facility's Resident Abuse policy read, "Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation.."

On 3/16/17 at 3:00 p.m., the administration was informed of the staff's failure to protect Resident

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	495235	A. BUILDING _____ B. WING _____	C 03/16/2017

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ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(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 223	Continued From page 12 #15 immediately after a resident- to- resident sexual abuse incident.	F 223		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are	F 225	1. Resident #15 was assessed by physician after being informed that she was "sexually assaulted" by resident #2. No trauma, no bleeding or swelling noted. Social Service will follow the resident for psychosocial support weekly or as needed. Facility submitted a Facility Reported Incident form to OLC of Virginia and all appropriate agencies. CNA E was educated on the proper procedure for resident to resident abuse includes: separate and protect resident immediately. 2. Any resident that encounters a resident to resident altercation has the potential to be affected. 3. The facility staff will be re-educated on company's abuse policy. Facility staff will complete quiz on abuse to validate understanding of policy and procedure.	04/18/2017

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F 225	Continued From page 13 reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 implement the abuse prevention policy for two Residents (Residents #15 and Resident #2) in a survey sample of 24 residents. Resident #15 was sexually assaulted by Resident #2. The facility staff failed to immediately separate and protect Resident #15 from Resident	F 225	4. The DCS/designee will conduct random audits with facility staff on the proper procedure for abuse 4xs a week for 30days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/17	

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F 225	Continued From page 14	F 225		

#2 after becoming aware of the assault.

The findings included:

Resident #15 was admitted to the facility 12/20/13. Her diagnoses included non-Alzheimer's dementia and hypertension.

Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/12/17 was coded as a quarterly assessment. Resident #15 was coded a BIMS (brief interview of mental status) score of 5, severe impairment. She was coded as needing extensive to total assistance of one staff member to perform her activities of daily living, except for eating. For eating she required limited assistance by staff. Resident #15 was incontinent of bowel and bladder. Resident #15 had no range of motion limitations and her primary mode of mobility was her wheelchair. Resident #15 was coded for no behaviors and no wandering.

Resident #2 was admitted to the facility on 5/4/16 and readmitted from the hospital on 9/28/16. Her diagnoses included hypertension, hemiplegia and hemiparesis following a stroke affecting her left non-dominant side, diabetes and major depressive disorder.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/3/17 was coded as a quarterly assessment. Resident #2 was coded a BIMS (brief interview of mental status) of 11, moderate cognitive impairment. She was coded as needing limited to total assistance of one staff member to perform her activities of daily living except for

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eating. For eating she required limited supervision by staff. Resident #2 was incontinent of bowel and bladder. Resident #2 had range of motion limitation on one side and her primary mode of mobility was her wheelchair. Resident #2 was coded for no behaviors and no wandering.

On 3/14/16 at 2:30 p.m., Resident #2 was observed in her room in her bed. She was watching a maintenance staff member as he repaired the air conditioner in her room. Resident #2 was very talkative and denied having any concerns or discomfort. Resident #2's bed was beside the window and she shared a room with Resident #15, whose bed to perpendicular to her bed and located near the door.

On 3/14/16 at 3:00 p.m. Resident #15 was observed sitting in the dining room area in her wheelchair where she was staring out of large glass window. Resident #2 was appropriately dress and responded quietly, though confused at times, to conversation.

On 3/15/16 at approximately 10:00 a.m., the administrator announced to the survey team that Resident #15 sexually fondled Resident #2 and that Resident #15 was being sent to the emergency room for evaluation. The administrator said the plan was to separate the residents and send a Facility Reported Incident (FRI) to the Office of Licensure and Certification. At the time of this announcement, there was a police officer in the facility addressing the incident. The administrator said Resident #15 would most likely be the one to change rooms because there were no private rooms available.

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The administrator said Resident #2 would be staying in the same room without a roommate.

On 3/15/16 at 10:30, a review of Resident #15 and Resident #2's clinical record was initiated and the review revealed the following:
a. Resident #2's progress note dated 3/15/17 at 6:27 a.m., "MD and PT OWN RP (responsible party) MADE AWARE OF PT FONDLING ANOTHER RESIDENT. At 9:56 a.m. a note read, "MD examined resident and found no injuries, gave new orders to send res. to ER for evaluation r/t earlier inappropriate incident with roommate. At 10:25 p.m. a note read, "Report from hospital, reports resident is on Antibiotic for UTI (urinary tract infection). Upon arrival, began on 1:1 supervision at all times."

b. Resident #15's progress note dated 3/15/17 at 6:29 a.m., "..Resident was found being fondled by another resident." At 9:47 a.m., "PATIENT WAS EXAMINED THIS AM AFTER STAFF MEMBER REPORTED INAPPROPRIATENESS. PATIENT HAS NO NOTED VAGINAL TRAUMA-NO SWELLING OR BLOOD COMING FROM VAGINAL AREA. PATIENTS BRIEF WAS CHANGED AND PERICARE COMPLETED-NO DISCHAREGE NOR BLOOD WAS NOTED." Author: Physician, Emp. Q

c. A Facility Reported Incident dated 3/15/17 was coded as a Resident to Resident incident described the incident and action taken: "It was reported that nursing staff observed [Resident #2's name] was @ her roommate [Resident #15's name] bedside and her hand was@ [Resident #15's name] private area. Two patients were separated immediately. [Resident #2's name] was placed on one on one supervised."

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Signed by the Administrator and faxed to the OLC at 10:09 a.m.

On 3/15/16 at 2:00 p.m., a request was made to the administrator and the DON (director of nursing) to interview the staff member that initially witnessed the incident. The DON said CNA (certified nursing assistant) E witnessed the incident and she worked on the night shift.

On 3/16/16 at 8:15 a.m., the administrator and the DON were asked again to arrange an opportunity for an interview with CNA E.

On 3/16/16 at 11:00 a.m., a telephone interview was conducted with CNA E. When asked what happened when she saw the two residents, CNA E stated, "I was doing rounds, passing ice, when I saw Resident #2 sitting at the foot of Resident #15's bed with her hand down in Resident #15's brief." When asked what she did after that, CNA E stated, "I told Resident #15 to not move, stay right there, and I went down the hallway to the nurse's station to get two other nurses." CNA E said she wanted the nurses to witness what she saw. CNA E said after she and the two other nurses, returned to the room, Resident #15 was in the same position and Resident #2 was in and out of sleep. CNA E stated, "She (Resident #15) is hard to wake up, she is a heavy sleeper." CNA E said she and the other nurses separated the residents and the nurse examined Resident #15. CNA E said, "She (Resident #2) said she thought her roommate (Resident #15) was a man." When asked how long she left the residents alone after she identified the incident, CNA E stated, "Oh not long, I am tall and I have long legs."

A review of the facility floor plan displayed the

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hallway in which Resident #2 and Resident #15 resided. There were eight resident room between their room and the nurse's station.

On 3/16/16 at 11:30 a.m., the administrator provided copies of the staff Witness Statements dated 3/15/17 which read as follows:
a. CNA E wrote, "I notice the resident (Resident #2) from bed B sitting on the foot of[Resident #15's name] I went immediately to tell the nurses LPN (licensed practical nurse) E and LPN F and they both came down to the room."

b. LPN E wrote, "CNA E came to the nurse's station to report to the charge nurse, LPN F and myself, LPN E, night supervisor that [Resident #2's name] was sitting on her roommates bed with her hand inside her brief. "

c. LPN F wrote, "CNA notified nurse to come to residents room. [Resident #2] was sitting on [Resident 315's name] bed with brief area moving open fingers were in [Resident #15's] groin area moving hand. [Resident #2's name] states [Resident #15] was a man and [Resident #15's name] was not compl. (sic) Resident #2 made to wash hands and Resident #15's skin checked. Resident #2 placed at nurses station until 6 am then placed in room for 1:1 with nurse till day shift arrived."

At approximately 11:20 a.m., Resident #15 was observed in a different room, it was the room directly next door to her prior room. Resident #15 was now in a bed beside the window and she was seated in her wheelchair looking out her bedroom window. Her affect was pleasant and she answered, "Yes" when asked if she liked her new room.

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F 225	Continued From page 19 At 11:30 a.m., the unit manager, RN (registered nurse) A, was interviewed and said Resident #2 was transferred to the emergency room earlier that morning due to a change in her mental status. On 3/16/17 at 12:00 p.m., the interview with CNA E and the review of the witness statements were shared with the administrative staff. All evidence indicated that Resident #15 was left alone with Resident #2 when a staff member witnessed an occurring sexual assault. Based on the assessment of Resident #15's cognitive status, Resident #15 was not cognitively able to consent to a sexual interaction with Resident #2. When asked what was the facility's expectation regarding this sexual incident between these two residents and the corporate nurse, Emp C, said the incident should have been treated just like any Resident-to-Resident incident and added, "Immediately separate the residents and keep the resident safe." A review of the facility's Resident Abuse policy read, "Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation..." On 3/16/17 at 3:00 p.m., the administration was informed of the staffs failure to implement their abuse policy to immediately protect Resident #15 after a resident- to- resident sexual abuse incident. No additional information was provided.	F 225		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has	F 246		

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F 246	Continued From page 20 a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, facility and clinical record review and in the course of a complaint investigation, the facility failed for one resident (Resident #4) in a survey sample of 24 residents, to ensure reasonable accommodation of needs. Resident #4 was not provided with a footrest for the right side of his electric wheelchair. The findings included: Resident #4 was admitted to the facility on 8/24/16 with diagnoses which included, but not limited to, spinal cord injury with quadriplegia, neurogenic bowel and bladder and autonomic dysreflexia. Resident #4's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/24/17. Resident #4 was coded with a Brief Interview of Mental Status score of "14" out of a possible 15 indicating no cognitive impairment. Resident #4 required total assistance of one to two staff members for bed mobility and dressing and toileting. There were no mood or behavioral issues.	F 246	1. DME company staff has provided a new footrest for resident #4. DMAS has approved his new power chair application. 2. Residents with power chairs that need footrests have potential to be effected. 3. An audit was completed for residents that have power chairs to assure they have the proper footrests. Staff will be re-educated on P/P reporting and repairing broken equipment. 4. Mock surveyors will audit the power chairs for proper footrests 4xs a week for 30days, then 2xs a week for 30 days. Any repair needs will be reported to the morning meeting for follow up. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	04/18/2017

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On On 3/14/17 at 2:05 PM, Resident #4 was observed in his room in his electric wheelchair. A splint was in place on the right hand, and the left splint was on his lap. He was missing the right foot rest and pedal on the wheelchair, with his right leg dangling in space. He was able to cross his right foot and leg to rest on the left side pedal. The resident stated, "It's been gone over 110 days." When asked how did it make him feel, the resident stated, "It hurts."

Review of the clinical revealed a PT (physical therapy) note dated 9/7/16 which read: "Power wc (wheel chair); getting a new power wc, currently legs fall off footrest....current wheelchair is from the FREE Foundation" and was donated to him. Resident still has not gotten a new power wheelchair due to extended length of time getting Medicaid approval.

On 3/15/17 at 1:15 PM, an interview was conducted with the rehab manager who is a COTA (certified occupational therapist assistant) and has been employed at this facility for two years. She stated, "This is the first time I know he was complaining that the wheel chair leg had broken." "I can see if they will fix it."

On 3/16/17 at 9:30 AM, Resident #4 was in his room, up in the power chair. The left footrest had been removed and the wheel chair leg rest/ foot pedal had been placed in the center front of the wheel chair. The resident was able to rest both feet on the pedal.. He stated, "I am OK with it, I am getting the new wheel chair soon." The business office had contacted DMAS (department of medical assistance) on 3/15/17 and his application had been approved this week.

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F 246	Continued From page 22 On 3/15/17 at approximately 5:15 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 246		
F 251 SS=E	483.70(p)(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS (p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure the facility employed a qualified social worker. The social worker employed by the facility failed to have any prior social work experience prior to being hired at the facility. The findings included: During the course of a complaint investigation regarding questionable inappropriate sexual behaviors by several of the Residents, the staff	F 251	1. We have a qualified full time social worker started working at our center on March 16, 2017. We also hired another full time qualified social worker with the starting date of April 13, 2017 2. All residents have potential to be affected. 3. Facility will follow CMS guideline when hires the new social worker in the future. 4. Administrator or designee will monitor the compliance. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	04/18/2017

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member identified by the administrator as being the social worker, was interviewed, 3/15/17 at 10:26 a.m. EMP. J, stated he had been employed by the facility for approximately three months. EMP J stated he had been initially hired as a social work assistant. The social worker at the time of his hire had been at the facility for a number of years and had been his supervisor.

EMP. J stated he had a BS (bachelor of science) in sociology and a masters in public administration. EMP. J stated this facility was his first employment in the social work field, with his previous experience in retail. He stated he had done internships in business.

EMP. J stated, with the leaving of the previous social worker, he had been assigned her duties including:

1. Handle concerns regarding Residents, families, and staff;
2. Arrange transportation;
3. Complete Section C, D, E, Q in the MDS (minimum data set) (cognition, delirium, and behaviors) and assist with care planning for those concerns in the care plan;
4. Handle discharges and discharge planning;
5. Handle Medicaid pending concerns in conjunction with the business office; and
6. Function as an overall advocate for the Residents.

EMP J stated, other than his orientation at the time of his hire, he had not had any additional educational opportunities that focused on his job as the facility social worker. Review of EMP J's employment information revealed he was hired as a social work assistant on 11/28/16.

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His employment information also revealed he had a degree in sociology and criminal justice and a masters degree in public administration. He also had one four month internship as a "career readiness intern" and another two month internship as "human resources intern." Prior to his employment at the facility, he was working as a "sales associate" at a local fragrance store.

EMP A, the facility administrator, stated 3/15/17 at 10:30 a.m., she functioned as EMP J's supervisor. EMP A stated she had a bachelor's degree in nursing with a master's degree in nursing administration and health policy. EMP A stated EMP J had been functioning as the facility's social worker since the other social worker left at the end of February, 2017. EMP. A stated that EMP J could function as the facility social worker as he had a degree in sociology. EMP A said that the need for one years experience was an "OR" in the requirements as "an appropriate degree or one year's experience.

EMP A stated EMP J had been to some of the corporate other long term care facilities for social work experience, however there was no evidence of that. EMP A also stated EMP J was scheduled to take an MDS inservice to facilitate his job requirement to complete the appropriate sections of MDS.

Review of the clinical records of Residents within the sample revealed that after the previous social worker left, EMP J signed his notes as "social worker." An example of his notes included:

"Resident has behaviors of delusion of being Jesus, noncompliance with care or treatment,

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F 251	Continued From page 25 and socially inappropriate behavior. Resident has DX (diagnoses) of schizoaffective, delirium, known physiological condition, and disorganized schizophrenia. Resident is stable. The resident was last seen by psych..." The administrator, DON (director of nursing), and corporate consultants were informed of the failure of the facility to employ a qualified social worker, 3/16/17 at 11:35 a.m.	F 251		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (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. (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.	F 252	1. A) Resident #8 and #9's ceiling air vents covers are cleaned and re-painted. Both vents are working properly. B) Housekeeping staff have been cleaning the rooms, hallways to eliminate any odor. There is no more pervasive odor noticed. 2. All residents have potential to be affected. 3. A) Maintenance staff will audit all resident room ceiling air vents to assure there is no rust and it works properly. B) Mock Surveyors and staff that notice of the odor will notify housekeep staff or administrative staff to determine the cause of the odor and the solutions. Staff will be re educated on P/P of keeping the environmental safe and odor free.	04/18/2017

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F 252	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to ensure a homelike environment for 2 residents(Residents #8 and #9) of 24 residents in the survey sample, and failed to prevent pervasive odor throughout the facility. 1. Resident #8's ceiling air vent cover was rusted and per the resident, non functional. 2. Resident #9's ceiling air vent cover was rusted. 3. During the initial tour of the facility on 3/14/2017 at 2:00 PM, foul odors were noted on 2 of 3 units on the Liberty and Freedom Unit. During the course of the survey, foul odors persisted on the Freedom Unit. The findings included: 1. Resident #8's ceiling air vent cover was rusted and, per the resident, not functional. On 3/14/17 at 2:25 p.m., during initial tour of the facility, Resident #8 was observed sitting in a lounge chair in her room, next to the wall, facing the foot of her bed. She was alert and talkative. During general conversation, Resident #8 pointed to the ceiling vent near the window and stated "See that, it's been that way since I've been here." She explained the vent was covered with cardboard then the slotted cover was placed over it to avoid air blowing on her. The ceiling vent was observed as she described and it had rusted areas throughout the slots. Resident #8 stated "The lever was rusted so the vent could not be closed." She then stated she told maintenance (Employee-F) and he said he'd fix it but stated	F 252	4. A) Maintenance staff will audit resident room ceiling air vents weekly for 4 weeks, then monthly. B) Mock Surveyors will monitor the odors 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	

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"It's been quite some time." A piece of white tape was also observed on the left edge of the vent and on the ceiling.

On 3/15/17 at 10:05 a.m. Resident #8's ceiling vent cover was observed again with the taped and rusted areas present.

On 3/15/17 at 2:40 p.m., the Unit Manager, Licensed Practical Nurse-C) was informed and shown the taped and rusted air vent cover. When asked if she knew if the vent was to be changed she explained "Maintenance would have a report sheet and could tell if the item was ordered." When asked how maintenance would be notified of work that needed to be done, she stated "He would be informed during the (daily) stand up meeting," No further information was provided.

An interview with the Maintenance Director (Employee-F) was conducted on 3/15/17 at 3:00 p.m. When questioned about the rusted ceiling vent cover, Employee-F explained that when the weather gets warm they take down the vents, vacuum inside, wash them down and spray (paint) them. He stated he "Was planning on doing the whole hallway but it got cold out again." He stated they do it outside. The surveyor requested documentation on the cleaning schedule of the vents.

On 3/15/17 at 3:50 p.m. Employee-F approached surveyor and stated he "Just ordered the ceiling vent covers because due to the weather everything is set back." Employee-F stated he'll "Just replace them." Employee-F presented an order form dated 3/15/17 for "35 12x6" Single Deflection Sidewall/Ceiling Register."

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The Administrator and Director of Nursing were informed of the rusted ceiling vent cover. No further information was provided.

2. Resident #9's ceiling air vent cover was rusted.

During initial tour of the facility on 3/14/17 at approximately 2:45 p.m., Resident #9 was observed sitting up in bed with the television on. She was alert and talkative with forgetfulness. The ceiling air vent cover was observed near the window with rusted areas on the slots and around the perimeter. Resident #9 did not mention the vent cover to the surveyor.

On 3/15/17 at 10:10 a.m., Resident #9 was out of her room. Upon inspection, the ceiling vent cover was observed again with the rusted areas present.

Interviews and responses were conducted as described above in Resident #8's writing. No further information was provided by the facility staff.

3. During the initial tour of the facility on 3/14/2017 at 2:00 PM, foul odors were noted on 2 of 3 units on the Liberty and Freedom Unit. During the course of the survey, foul odors persisted on the Freedom Unit.

On 3/14/2017 at 2:00 PM during the initial tour of the facility, several surveyors noticed foul odors on two units (Liberty and Freedom Units).

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On 3/15/2017 at 3:40 PM, two surveyors were sitting at the nurses station on the Freedom Unit. A very pungent, foul smell was noted. An interview was conducted with the nurse, who stated there was a resident on the unit who often refused to bathe or shower and that she thought that might be the smell. The nurse stated she would ensure that resident was provided a shower.

The Unit Manager (Registered Nurse A- RN A) came to the unit and stated she did notice a foul smell. RN A stated the Soiled Utility room was adjacent to the Nurses station and that the smell could be coming from that room. RN A stated there were a couple of residents who refused regular showers and that she would investigate to determine the cause of the smell.

On 3/15/2017 at 4:40 PM, the Administrator stated she also noted the pungent odor on the Freedom Unit and was told that a resident on that unit often refused showers and baths. The Administrator stated she instructed the nursing staff to use creative interventions to encourage the resident to consent to showers.

On 3/15/2017 at 5:00 PM, the foul odor was still noticed on the Freedom Unit.

The Director of Nursing stated the Housekeeping Department utilized a schedule where rooms were cleaned regularly. The Director of Nursing stated the nursing staff had tried many measures to include to rotate staff members assigned to work with the resident to see if he would respond.

On 3/16/2017 at 9:30 AM, an interview was conducted with the Housekeeping Manager

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F 252	Continued From page 30 (Employee P) who stated there were a couple of residents on the Freedom Unit who often refused to shower. The Housekeeping Manager stated the Housekeeping staff cleaned the rooms and halls daily. Employee P stated deep cleaning of one room per housekeeper per day was the expectation. Employee P presented a copy of the Deep Cleaning schedule. Review of the schedule revealed that every room was scheduled for deep cleaning every 4 weeks. A General Observations of the Facility Tour was conducted on 3/16/2017 at approximately 9:45 AM with the Maintenance Director (Employee F) and Employee P. During the Tour, foul odors of urine were not noticed on the Liberty and Freedom units. Several housekeeping staff persons were observed to be cleaning rooms and mopping hallways during the Facility Tour. During the end of day debriefing on 3/16/2017 at 12:10 PM, the facility Administrator, Director of Nursing and Corporate Consultant (Employee C) were informed of the findings. No further information was provided.	F 252		
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:	F 281		

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F 281	Continued From page 31 Based on staff interview, clinical record review, and facility documentation, the facility staff failed to follow professional standards of nursing for medication and treatment administration for four Residents (Residents' #7, #8, #1 and #21) in a survey sample of 24 Residents. 1. For Resident #7, the facility staff failed to ensure medications and treatments were administered and documented on 3/7/17 and 3/12/17; 2. For Resident #8, the facility staff failed to administer the physician ordered pain medication, oxycodone-acetaminophen (Percocet), on 6 occasions citing the medication was not available for administration; however, the Percocet was listed as available in the facility emergency box; 3. The facility staff failed to document the administration of medications for Resident #1; and 4. For Resident #21, the facility staff failed to document the administration of medication for Hypertension, and Hypothyroidism. The facility staff stated the facility utilized "Lippincott" as their professional nursing standard. The findings included: 1. For Resident #7, the facility staff failed to ensure medications and treatments were administered and documented. Resident #7, a male, was initially admitted to the facility 3/2/01. His diagnoses included aphasia,	F 281	1. Residents #7, #8, #1 and #21 have received their medications and treatments as ordered. Resident #7 orders for Atorvastatin, Levemir, Senna, Moisture barrier cream have been administered as ordered. Physician was notified of the omitted administration of medications and treatments. No adverse effects noted from omission of medications. Resident #8 orders for Percocet has been administered as ordered. Physician was notified of the omitted administration of medication. No adverse effects noted from omission of medications. Pain assessment was completed on resident #8. Resident #1 orders for Atorvastatin, Depakote, Lantus, Brimonidine, Clonidine, Gabapentin, Levetiracetam, Humalog, Hydralazine and Isosorbide Dinitrate have been administered as ordered. Physician was notified of the omitted administration of medications. No adverse effects noted from omission of medications.	04/18/2017

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F 281	Continued From page 32 type II diabetes mellitus, hemiplegia, monoarthritis, vascular dementia with behavioral disturbances, hypothyroidism, hyperlipidemia, osteoporosis, major depressive disorder, hypertension, seizures, and iron deficiency anemia. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/17/16 was coded as a quarterly assessment with a subsequent modification. Resident #7 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as requiring extensive to total assistance of one to two staff members to perform his activities of daily living. Review of Resident #7's clinical record revealed no evidence the following medications and treatments were administered: Atorvastatin 10 mg at bedtime (hyperlipidemia): 3/7/17 Levemir insulin 15 units at bedtime (type II diabetes mellitus): 3/7/17 Senna 8.6-50 mg (milligrams) at bedtime (constipation): 3/7/17 Moisture Barrier apply to buttocks every shift and after each incontinent episode: 3/12/17 day shift A valid physician's order was evident for the medications and treatments in question. Review of the facility's policy entitled "Medications - Oral administration of" included: "Chart on MAR (medication administration record) according to policy."	F 281	Resident #21 orders for Levothyroxine, Clonidine and Hydralazine have been administered as ordered. Physician was notified of the omitted administration of medications. No adverse effects noted from omission of medications. 2. Residents that reside in the facility that have orders for medications and treatments have the potential to be affected. 3. The facility licensed nurses will be in-serviced on documentation for medication and treatment administration given. Licensed nursing staff in-serviced on using dash board to check for completion of documentation in MAR/TAR prior to leaving for the day.	

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F 281	Continued From page 33 The DON (director of nursing) stated 3/16/17 at 12:28 p.m., the expectation was for the staff document medications when they are administered on the eMAR (electronic MAR). Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." The administrator, DON, and corporate consultants were advised of the failure of the staff to ensure staff administered and documented medications and treatments as having been administered for Resident #7, 3/16/17 at 11:35 a.m. 2. For Resident #8, the facility staff failed to administer the physician ordered pain medication, oxycodone-acetaminophen (Percocet), on 6 occasions citing the medication was not available for administration; however, the Percocet was	F 281	4. The DCS/ designee will audit documentation in MAR/TAR for medication and treatment administration 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 0 4/18/17	

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listed as available in the facility emergency box.

Resident #8 was admitted to the facility on 4/20/15 with the diagnoses of, but not limited to, spinal stenosis, osteoarthritis, lower back pain and anxiety.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/16/16. The MDS coded Resident #8 with no cognitive impairment; required set up to no assistance with activities of daily living; was continent of bowel and bladder; and had occasional pain with an average pain scale of 4 (out of 10).

On 3/14/17 at 2:25 p.m., Resident #8 was observed in her room sitting in a lounge chair with 2 visitors exiting the room. She was alert and talkative. A Resident interview was conducted and when asked about physician visits, she stated she has seen her doctor and "He ordered me pain medication..." Resident #8 did not complain of pain.

On 3/15/17 at 8:50 a.m. Resident #8's clinical record was reviewed. The review revealed pain assessments were completed each shift for the months of February and March 2017. Physician orders were reviewed and revealed the following medications for pain management:

Oxycodone-Acetaminophen (Percocet) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 8 hours for Pain,
Voltaren Gel 1 % (Diclofenac Sodium) Apply 4 gram transdermally as needed for Pain apply to elbows and knees as needed 4 x daily,
Mapap Tablet 325 mg (Acetaminophen) Give 2

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tablet by mouth every 4 hours as needed for Pain.

Resident #8's Medication Administration Record (MAR) for the months of February and March 2017 were reviewed. The review revealed the Percocet was administered as ordered throughout the month of February and the as needed (PRN) Mapap was administered on 3 occasions (2/11, 2/24 & 2/25/17).

Review of March 2017's MAR revealed the following:

The Percocet was administered as ordered 3/1-3/11 at 6 a.m., 2 p.m. and 10 p.m. From 3/12/17 at 10 p.m. through 3/14/17 at 10 p.m. the medication was documented as "9=Other/See Nurse Notes." Review of the Progress Notes for the corresponding dates had documentation that read "Not available awaiting pharmacy to deliver." There was no documentation that the pharmacy or physician was called.

Resident #8 received PRN Mapap for complaints of back pain or headache on 3/9/17 at 11 p.m., 3/11 at 9:06 p.m., 3/12 at 9:28 p.m., 3/13 at 4:38 p.m. and 3/14/17 at 6:11 a.m. The PRN pain medication was documented as effective.

On 3/15/17 at 2:45 p.m. an interview was conducted with Licensed Practical Nurse-B (LPN-B). LPN-B showed surveyor upon request the blisterpack (medication package) containing Resident #8's percocet. The processing date on the package 3/14/17 with a quantity of 9 tablets. There were 2 tablets missing from package which would have corresponded to the doses given on 3/15/17 at 6 a.m. and 2 p.m. LPN-B explained that Resident #8 gets the pain medication every 8

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hours and she gave the 2 p.m. dose today. When asked about the process to obtain the medication if it was not available in the medication cart she stated "If (the) script is still good, (we) fill out pharmacy sheet and they would give us a code to get it out of the stat box." She stated "If no active script we need to wait for the doctor to call it into the pharmacy and then write a hard (paper) script." When asked if she was unable to get a response from the doctor, LPN-B stated they could call the medical director (Employee-Q) or the covering physician. When asked to see the stat box process, LPN-B brought surveyor into the medication room and locked in a cabinet was a "pharmacy control box" with a code lock present. LPN-B explained the pharmacy needed to give the code to open the combination lock.

Review of the stat box medication list included but was not limited to:

Oxycodone/APAP (Percocet) 5MG/325MG TAB ORAL with a quantity of 5,
Oxycodone/APAP 7.5/325 MG TAB ORAL with a quantity of 2, and
Oxycodone 5MG TAB ORAL with a quantity of 5.

On 3/15/17 at 3:05 p.m. an interview was conducted with the nurse on duty 3/14/17 at 10 p.m. (LPN-A). When asked why he didn't obtain the Percocet from the stat box at the time it was due, LPN-A stated, "I called the pharmacy and they stated it was already sent out (the new blisterpack)." And "It was on the 5 o'clock run." LPN-A stated he "Told the 11p-7a nurse to give it once it arrived and that he gave her (Resident #8) Tylenol."

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Resident #8's care plan revised on 10/18/16 included:
"Focus..chronic alteration in pain/comfort r/t (related to) spinal stenosis, DJD (degenerative joint disease), arthritis, anxiety, depression. Resident has an effective pain management program..." "Interventions..."Administer analgesia as per orders and prior to treatment or care prn..."

On 3/15/17 at 4:55 p.m., the Director of Nursing (Employee-B) and the Administrator were informed of the Percocet not administered due to the medication not being available. When asked what professional standard reference was used by the facility, Employee-B stated "Lippincott."

Facility policy titled "Medications- Oral Administration Of" dated 11/30/14 was reviewed. The policy included:
"Policy: It is the policy that the resident can expect safe and accurate administration of oral medication."
"Procedure: ...Locate prescribed medication in Medication Cart..."
"...Chart on nurse's notes: Pertinent observations immediately after administration."

Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary. Page 584 read: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an

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inconsistency in adhering to these rights:
1. The right medication
2. The right dose
3. The right patient
4. The right route
5. The right time
6. The right documentation

On 3/16/17 at 9:10 a.m. an interview was conducted with the Director of Nursing (Employee-B). When asked what her expectations were if medications were unavailable, Employee-B stated she would "Expect the nurses to get a new script if needed (from the doctor) if it was running out." She stated she would "Expect the nurses to document contacting the MD (doctor) and pharmacy, get the meds out of stat box if able or get another med ordered." Employee-B stated she spoke with the nurses that were identified and they have been educated on the process.

3. The facility staff failed to document the administration of medications for Resident #1.

Resident #1, an 85 year old female, was admitted to the facility on 6/1/2015 and readmitted on 11/27/2016. Her diagnoses included diabetes, dementia, coronary artery disease, muscle weakness, cognitive communication deficit, osteoporosis, dysphagia, seizures, anemia, glaucoma and hypertension.

Resident #1's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/3/2017

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was coded as a quarterly assessment. She had a BIMS (Brief Interview of Mental Status) score of 6/15, indicating severe cognitive impairment. She required extensive assistance of one person for her activities of daily living and was frequently incontinent of bowel and always incontinent of bladder.

A clinical record review was conducted on 3/13/2017 at 4:40 PM and revealed MAR's (Medication Administration Records) for March 2017 showing no documentation for physician orders for the following medication on the dates and times indicated:

Atorvastatin 80 mg (milligrams) give one tablet by mouth at bedtime-3/7 9:00 PM
Depakote 500 mg by mouth at bedtime-3/7 9:00 PM
Lantus solution inject 34 units at bedtime-3/7 9:00 PM
Brimonidine solution 2% one drop in left eye two times per day-3/7 5:00 PM
Clonidine 0.3 mg by mouth 2 times a day-3/7 5:00 PM
Depakote 250 mg one tablet by mouth two times a day-3/7 5:00 PM
Gabapentin 100 mg one capsule by mouth two times a day- 3/7 5:00 PM
Levetiracetam 500 mg by mouth every 12 hours-3/7 9:00 PM
Humalog Insulin solution inject 5 units subcutaneously before meals-3/7 4:30 PM
Hydralazine 50 mg one tablet by mouth every 8 hours-3/7 9:00 PM; 3/9 9:00 PM
Isosorbide Dinitrate 5 mg one tablet by mouth 3 times a day-3/7 5:00 PM

A review of the physician orders revealed current

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and active orders for the above mentioned medications for Resident #1.

Employee B. Director of Nursing was informed of these omissions on 3/15/2017 at 4:10 PM. She offered no explanation for this situation.

Facility Policies and Procedures regarding the oral administration of medications stated "It is the policy that the resident can expect safe and accurate administration of oral medication".

Guidance for nursing standards for the administration of medication is provided by Fundamentals of Nursing, 7th Edition, Potter and Perry, p705: Professional standards such as the American Nurses Association, Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. "To prevent medication errors, follow the six rights of medication administration. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation"

Administration was informed of findings on 3/16/2017 at 3:00 PM.

4. For Resident #21, the facility staff failed to

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document the administration of medications for thyroid, and high blood pressure.

Resident #21 was a 52 year old who was admitted to the facility on 5/30/16. Resident #21's diagnoses included Hypertension, Hypothyroidism, and Generalized Muscle Weakness.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/23/17, coded Resident #21 as having a Brief Interview of Mental Status Score of 15, indicating that she was cognitively intact, without impairment.

On 3/15/17 a review was completed of Resident #21's clinical record, revealing the following care plan: "2/1/17. The resident will be free of unrelieved cardiac symptoms, elevated blood pressure through next review."

Resident #21's Physician Orders read: "2/1/17. Levothroid Tablet 75 MCG (micrograms). Give 1 tablet by mouth in the morning related to Hypothyroidism, Unspecified. Clonidine HCl Tablet 0.1 MG (milligram). Give 1 tablet by mouth three times a day related to Essential Hypertension. Hydralazine HCl Tablet 100 MG. Give 1 tablet by mouth three times a day related to Essential Hypertension."

On 3/15/17 a review of Resident #21's Medication Administration Record (MAR) was conducted, revealing missing documentation of administration of the following medications:

1. Levothroid Tablet 75 MCG (micrograms). Give 1 tablet by mouth in the morning related to

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F 281	Continued From page 42 Hypothyroidism, Unspecified. 2/8/17 at 6:00 A.M. 2. Clonidine HCl Tablet 0.1 MG (milligram). Give 1 tablet by mouth three times a day related to Essential Hypertension. 2/8/17 at 6:00 A.M. 3. Hydralazine HCl Tablet 100 MG. Give 1 tablet by mouth three times a day related to Essential Hypertension. 2/8/17 at 6:00 A.M. A review of the Nursing Notes for February, 2017 revealed that the medication administration had not been documented. A review of facility documentation was conducted on 3/15/17. the Oral Administration of Medications Policy, dated 11/30/14 read, "It is the policy that the resident can expect safe and accurate administration of oral medication. Chart on MAR according to policy." On 3/16/17 at 12:30 P.M. an interview was conducted with the Director of Nursing (Employee B). When asked to clarify the facility's policy on documentation of medication administration, the Director of Nursing stated, "You document on the MAR at the time of administration or on nursing notes." On 3/16/17 at 12:45 P.M. the facility Administrator (Employee A) was informed of the findings. No further information was received.	F 281		
F 309 SS=E	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	F 309		

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F 309	Continued From page 43 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: Based on resident interview, staff interview, facility document review and clinical record review the facility staff failed to provide the necessary care and services to maintain the highest practicable well being for five residents (Residents #10, #7, #13, #1 and #17) of 24	F 309	1. A) Physician was notified that resident #10 had 15 finger sticks that were greater than 400. Resident #10 received a new order to obtain HgbA1c and to increase his Lantus to 24units daily. Physician was also notified that the order for Trazadone was not implemented. Resident Trazadone order was discontinued by psych NP. Upon interview with resident #10 there has not been any sleep disturbances. B) Resident #7 drug regimen for diabetic control was implemented and will be reviewed every 2 weeks by physician for effective diabetic control. C) Resident #13 care plan has been updated with non-pharmacological interventions for behaviors associated with anxiety/aggression. Resident #13 has not been administered Ativan without non-pharmacological intervention documented.	04/18/2017

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F 309	Continued From page 44 residents in the survey sample. 1 For Resident #10, a. the physician was not informed of 15 finger stick blood sugar (FSBS) readings greater than 400, per physician's order and b. the facility staff failed to implement a physician order for Trazodone (an anti-depressant medication), per physician. 2. For Resident #7, the facility staff failed to act upon a monthly drug regimen review recommendation for diabetic control in a timely manner; 3. For Resident #13, the facility failed to ensure non pharmacological interventions were developed and implemented prior to administration of antianxiety medications; 4. The facility staff failed to follow physician orders for the administration of insulin for Resident #1. 5. Resident #17's pain management was not provided as the physician ordered. She missed multiple doses of her Fentanyl (pain) patch. The findings included: 1. a. Resident #10 was admitted to the facility initially on 8/25/16 and was readmitted after a hospitalization on 1/9/17. Diagnoses included glaucoma, diabetes, hypertension, dementia and seizure disorder. Resident #10 was observed in his room on 3/14/17 at 4:30 p.m. He was in his bed covered	F 309	D) MD notified of the omitted administrations of resident #17 fentanyl patch. Residents' fentanyl patch order has been discontinued. Resident #17 has a new pain management order in place and has been administered as order. License nursing staff will continue to monitor pain for effectiveness. Pain assessment has been completed on resident #17. 2. Residents with a diagnosis of diabetes and receive insulin with parameters have the potential to be affected. Residents with PRN psychotropic medications and pain medications have a potential to be affected.	

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F 309	Continued From page 45 with a Redskins blanket and wearing a hospital gown. Resident #10 was talkative regarding his stay in the facility. Resident #10 said he did not want to live in the facility, that he was bored and that he had spoken with the staff regarding finding another place to live, a place that was closer to northern Virginia. Resident #10 acknowledged he was receiving insulin injections and he said he could learn to give himself injections. A review of Resident #10's hospital documentation and facility clinical record was initiated on 3/15/17 at 8:30 a.m. A quarterly MDS (minimum data assessment) with an ARD (assessment reference date) of 1/20/17 coded Resident #10 a BIMS (brief interview of mental status) score of "15" out of 15, cognitively intact. Resident #10 was coded as needing staff supervision only with ADLs (activities of daily living). Diabetes was coded as an Active Diagnosis. Resident #10's comprehensive care plan included a plan for Risk for Metabolic Complications r/t (related to) diabetes. Interventions included, "1. Medications as ordered. 2. Notify MD (medical doctor) as indicated. 3. Blood Glucose levels as ordered ". Review of Resident #10's hospital documentation from 1/7/17 through 1/9/17 revealed he was admitted with a diagnosis of Diabetic Ketoacidosis (DKA). His blood sugar measurement on admission to the hospital was 466. (Reference Ranges - "Before a meal: 80-130 and 1-2 hours after beginning of the meal, less than 180." www.diabetes.org)	F 309	3. A) DCS instituted a new procedure to ensure all pharmacy recommendations are given back to unit managers prior to being scanned in PCC to ensure recommendation orders are entered. B) Licensed nursing staff will be re-educated on policy and procedure for insulin administration and documentation in MAR. C) In-service will also include documentation of non-pharmacological interventions prior to administration of PRN psychotropic medication; D) procedure for when medications are low or not available. 4. DCS/designee will conduct random audits on residents receiving insulin, PRN psychotropic medications, medication omissions and order entry from psych recommendation 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/17	

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"DKA is an acute complication of diabetes mellitus characterized by hyperglycemia.." Lippincott's Manual of Nursing Practice, 8th edition, p. 928.
"When your cells don't get the glucose they need for energy, your body begins to burn fat for energy, which produces ketones..... When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump to use glucose. When ketones build up in the blood, they make it more acidic. They are a warning sign that your diabetes is out of control or that you are getting sick." www.diabetes.org

On 1/10/17, after readmission to the facility, the physician wrote an insulin order which read, "Humalog Solution 100 unit/ml (milliter) Inject 5 unit subcutaneously before meals related to Type 2 Diabetes. Hold if blood sugar is less than 100. Contact MD if less than 60 or greater than 400".

Review of the January 2017 MAR (medication administration record) revealed finger stick blood sugar (FSBS) results that were greater than 400 on 1/11 at 5 p.m. (481); 1/12 at 5 p.m. (566); 1/17 at 5 p.m. (576); 1/18 at 5 p.m. (506); 1/20 at 5 p.m. (491); 1/21 at 5 p.m.(466); 1/22 at 12 p.m. (479) and 5 p.m. (491); 1/23 at 5 p.m. (583); 1/24 at 5 p.m. (412); 1/26 at 5 p.m. (488).
Review of the February 2017 MAR revealed FSBS results that were greater than 400 on 2/10 at 5 p.m. (498) and 2/14 at 12 p.m. (461) and 5 p.m. (411).

A thorough review of the clinical record did not reveal physician notification of the blood sugars in question.

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On 3/15/17 at 3:30 p.m., during an end of day briefing, the administrator and the DON (director of nursing) were informed of the FSBS measurements greater than 400 and without physician notification. The DON said she would follow-up.

On 3/16/17 at 9:50 a.m., a follow-up interview with the DON regarding the FSBS measurements in question was conducted. The DON said the order was not for sliding scale insulin and therefore the nurse didn't expect to see parameters in place for physician notification. The DON stated, "They (the nurses) didn't look at the summary tab to read the entire order." The DON said the expectation was for the nurses to follow the physician's order for notification.

On 3/16/17 at 10:10 a.m., unit nurse LPN (licensed practical nurse) D was interviewed as she opened the lap top computer to Resident # 10's MAR. LPN D stated," If you hit the 'MORE' tab, the entire physician order is visible." The entire order on the eMAR (electronic medication administration record) included , "Contact MD (medical doctor) if less than 60 or greater than 400".

On 3/16/17 at 10:15 a.m., the unit manager, LPN C was interviewed. LPN C said she had reviewed Resident #10's clinical record and found no evidence of physician notification of the blood sugar measurements that were greater than 400.

The facility's Insulin Administration policy was reviewed and did not include directions regarding parameters or physician notification.

Guidance for nursing practice for the

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

On 3/16/17 at 3:00 p.m., the administration was informed of the staff's failure to notify the physician of blood sugar measurements greater than 400 (milligrams/deciliter), per the physician's order. There was no additional information provided.

1. b. For Resident #10, the facility staff failed to implement a physician order for Trazodone (an anti-depressant), per physician orders. Trazodone is a prescription medicine used for the treatment of depression, however, it is also often used as a sleep aid.

Review of Resident #10's clinical record revealed a Psychiatric Evaluation dated 9/1/16. Under Present Problem read, "Resident c/o (complaining of) poor sleep, request for a 'sleeping pill'." Under Symptoms/Problems read, "Insomnia and Agitation". Under Medication Adjustment read, "Will add Trazodone 50 mg (milligrams), p.o. (by mouth) Qhs (at bedtime)."

Review of the physician orders revealed Trazodone 50 mg had not been transcribed on the physician order list for administration.

Review of the September 2016 MAR (medication administration record) revealed Trazodone was not listed as a medication for administration.

Review of a Pharmacy Consultation dated 9/6/16

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read, "[Resident #10's name] had a psych consult and [Physician's name] wanted to add TRAZODONE 50 mg qhs to his drug regimen, however this order has not been implemented." This Consult was signed by the director of nursing on 9/19/16. A hand written note on the Consultation Report signed by the mental health nurse practitioner on 9/23/16 read, "Resident sleeping. Trazodone not needed. Will change dx (diagnosis) for Haldol (an antipsychotic medication)."

Review of the Progress Note revealed a Social Services note dated 3/6/17 which read, "[Resident #10's daughter's name] would like to consult with the psych nurse concerning Resident #10's treatment and why Trazodone was d/c (discontinued) in September 2016."

On 3/16/17 at 9:50 a.m., an interview was conducted with Resident #10 regarding his sleep habits. Resident #10 stated, "I used to have some trouble sleeping, but not so much now."

On 3/16/17 at 11:50 a.m., an interview was conducted with the DON (director of nursing) during an end of day briefing. When asked about the Trazodone that was ordered by the psychiatrist and never implemented, the DON stated, "There was a breakdown in getting the psychiatrist's consult to the physician."

On 3/16/17 at 3:00 p.m., the administration was informed of the staff's failure to implement a physician order for Trazodone. There was no additional information provided.

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2. For Resident #7, the facility staff failed to act upon a monthly drug regimen review recommendation for diabetic control in a timely manner.

Resident #7, a male, was initially admitted to the facility 3/2/01. His diagnoses included aphasia, type II diabetes mellitus, hemiplegia, monoarthritis, vascular dementia with behavioral disturbances, hypothyroidism, hyperlipidemia, osteoporosis, major depressive disorder, hypertension, seizures, and iron deficiency anemia.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/17/16 was coded as a quarterly assessment with a subsequent modification. Resident #7 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as requiring extensive to total assistance of one to two staff members to perform his activities of daily living.

Resident #7 was observed 3/14/17 at 4:08 p.m. He was lying on his back and alert. Resident #7

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was verbal however unable to make his needs known. Staff was administering incontinence care at the time of the observation.

Review of Resident #7's clinical record revealed a pharmacy "Consultation Report" that was developed by the pharmacist after the monthly regimen review completed on on 9/6/16. The pharmacist made the following recommendations:

"(Resident #7's name) frequently requires insulin per sliding scale, despite routine therapy with Levemir 20 units qam (every morning) and 15 units qhs (at bedtime) and novolin R 5 units before meals.

Recommendation:

Please consider improving glycemic control by discontinuing sliding scale insulin and novolin R and increasing levemir to 20 units twice a day.

Rationale for Recommendation: Prolonged use of sliding scale insulin is ineffective for long-term glycemic control, can lead to hypo (low) or hyperglycemia (high blood sugar), increases resident discomfort, increases cost, requires more nursing time, may increase morbidity and has not been shown to improve glycemic control in the long-term care population.

If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences.

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Glucose monitoring should continue following any change in diabetic therapy."

The physician noted the recommendation and ordered " I accept the recommendation(s) above WITH THE FOLLOWING MODIFICATIONS(S):

D/C S/S (sliding scale)
Change to Lantus 20 u (units) qam (every morning) & 15 u qhs (at bedtime). BS (blood sugar) Fasting and before dinner only. Notify MD (less than) <50 or > (greater than) 400."

The order for the changes in Resident #7's diabetic management was dated as having been reviewed by the physician 9/28/16 (22 days after the pharmacy recommendation was developed).

Sliding scale insulin is a dose of insulin predetermined by the physician based on a finger stick blood sugar reading.

www.levemir.com: "Levemir®, a long-acting basal insulin, provides blood sugar control for up to 24 hours in adults with type 2 diabetes..."

www.lantus.com also provides guidance that Lantus insulin is a long acting insulin that may be used to treat Type I or Type II diabetes.

No hemoglobin A1C was available for review during the time in question. A hemoglobin A1C is a blood test obtained to determine long term diabetic control.

When interviewed regarding the 22 day lag between when the pharmacy recommendation was made and when reviewed by the physician, the DON (director of nursing) stated 3/15/17 at

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4:50 p.m., the pharmacy reviews are emailed to her (the DON). They are printed out and given to the unit managers for review. The unit managers, in September 2016, would put the reviews in a "MD book" that contained Resident issues that needed to be addressed. The DON stated the physician's would come to the facility to see their Residents and often times would leave without reviewing what had been put in their "book." The DON stated the recommendation had been put in the "book" and the floor nurses had failed to ensure the physician had reviewed the recommendation. Additionally, the DON stated there were other Resident concerns that had placed in the "book" that were not handled in a timely manner. The DON stated she was attempting to get the floor nurses to "round" with the physicians to ensure all identified Resident concerns were handled timely.

Guidance was provided at www.medline.nih.gov:

"People with diabetes are living longer and healthier lives. They now have a much lower chance of developing kidney failure, heart disease, and amputation than they did in the past, thanks to advances in controlling blood glucose, blood pressure, and cholesterol, and greater prevention and education efforts. Now, more than ever, it is important to see your healthcare providers regularly to treat diabetes effectively. They will check your cholesterol, blood sugar, blood pressure, and weight. You may be asked to take medicines. A healthy lifestyle, especially watching how much you eat and exercising every day, can help prevent heart attack and stroke. A daily 30-minute walk can help you manage diabetes and lower your chances of developing problems associated with diabetes, such as heart

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attack and stroke.
People with diabetes who keep their blood glucose (sugar) as close to normal as possible soon after they are diagnosed have fewer heart attacks later in life and far fewer problems with their eyes, nerves, and kidneys."

The administrator, DON, and corporate consultants were advised of the failure of the staff to ensure a pharmacy recommendation to improve diabetic control for Resident #7 was reviewed and acted upon by the physician in a timely manner, 9/15/17 at 4:50 p.m.

3. For Resident #13, the facility failed to ensure non pharmacological interventions were developed and implemented prior to administration of antianxiety medications.

Resident #13, a male, was initially admitted to the facility 9/24/15 and readmitted after a hospitalization 2/20/16. His diagnoses included unspecified dementia with behavioral disturbances, Alzheimer's disease. muscle weakness, unspecified lack of coordination, dysphagia, constipation, epilepsy, and mood disorder.

Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/28/17 was coded as an annual assessment. Resident #13 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #13 was also coded as needing total assistance of one to two staff members to perform his activities of daily living.

Resident #13 was observed 3/14/17 at 4:36 p.m.

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He was lying on his back with the head of the bed slightly elevated. Resident #13 appeared to be sleeping.

Review of Resident #13's clinical record revealed he was administered "Ativan solution 2 mg/ml (milligrams per milliliter) Give 0.25 ml orally every 6 hours as needed for anxiety" on 2/9/17 8:44 a.m., 2/10/17 8 a.m., 2/13/17 8:30 p.m., 2/19 8:42 a.m., 2/20/17 9:31 a.m., 2/24/17 8:43 a.m., 2/28/17 12 noon and 9:30 p.m., 3/2/17 8:17 a.m. and 8:23 p.m., and 3/3/17 at 5:21 a.m.

www.drugs.com stated:

"Ativan (lorazepam) belongs to a group of drugs called benzodiazepines. Lorazepam affects chemicals in the brain that may be unbalanced in people with anxiety.

Ativan is used to treat anxiety disorders."

An order was evident to discontinue the Ativan every six hours as needed and changed to every four hours as needed on 3/3/17 with Resident #13's increasing "agitation."

Ativan was administered 3/2/17 at 8:17 a.m. and 8:23 p.m. and 3/3/17 at 5:21 a.m.

On 3/3/17 an entry was evident within the nursing notes that included:

"Resident had increased anxiety while performing ADL (activities of daily living) care..."

The physician increased Resident #13's Ativan to "Give 0.5 ml by mouth every 4 hours as needed for Agitation/Pain." Documentation was evident

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Ativan (lorazepam) was administered 3/3/17 at 12:17 p.m., 3/4/17 12:06 a.m., 4:53 a.m., 3/5/17 4:44 p.m. and 11:03 p.m., 3/7/17 2:27 a.m. and 6:38 a.m., and 3/8/17 at 10:25 a.m.

Due to increasing the "agitation" Resident #13's physician then ordered "Haldol 2 mg (milligram)/ml 0.5 ml q 6 hrs PRN (as needed) agitation and Seroquel 25 mg po (by mouth) qhs (every bedtime) dx (diagnoses) agitation. on 3/8/17"

Haldol was administered to Resident #13 on 3/8/17 at 8:01 a.m., 3/11/17 6:14 P.M. and 11:36 p.m.
Guidance for the administration of Haldol at www.drugs.com:

"WARNING
Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with

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conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Haldol Injection is not approved for the treatment of patients with dementia-related psychosis (see WARNINGS).

Haldol (haloperidol) is indicated for use in the treatment of schizophrenia.
Haldol is indicated for the control of tics and vocal utterances of Tourette's Disorder.

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Haldol Injection is not approved for the treatment of patients with dementia-related psychosis (see BOXED WARNING)."

Haldol is an antipsychotic medication.

Review of the nursing progress notes revealed that for all the times Ativan (lorazepam) and Haldol were administered, there was no evidence the facility staff had clear definition of what "anxiety" or "agitation" symptoms were.

www.merriam-webster.com defines anxiety as "fear or nervousness about what might happen..."

and www.medical dictionary.com defines anxiety:

"In order to understand the diagnosis and treatment of anxiety, it is helpful to have a basic

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understanding of its symptoms.

SOMATIC. The somatic or physical symptoms of anxiety include headaches, dizziness or lightheadedness, nausea and/or vomiting, diarrhea, tingling, pale complexion, sweating, numbness, difficulty in breathing, and sensations of tightness in the chest, neck, shoulders, or hands. These symptoms are produced by the hormonal, muscular, and cardiovascular reactions involved in the fight-or-flight reaction. Children and adolescents with generalized anxiety disorder show a high percentage of physical complaints.

BEHAVIORAL. Behavioral symptoms of anxiety include pacing, trembling, general restlessness, hyperventilation, pressured speech, hand wringing, or finger tapping.

COGNITIVE. Cognitive symptoms of anxiety include recurrent or obsessive thoughts, feelings of doom, morbid or fear-inducing thoughts or ideas, and confusion, or inability to concentrate.

EMOTIONAL. Feeling states associated with anxiety include tension or nervousness, feeling 'hyper' or 'keyed up', and feelings of unreality, panic, or terror."

Agitation is defined by www.medlineplus.gov:

"Agitation is an unpleasant state of extreme arousal. An agitated person may feel stirred up, excited, tense, confused, or irritable."

Review of nursing progress notes revealed no evidence any non-pharmacological interventions were attempted prior to the administration of

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antianxiety medication and ultimately an antipsychotic medication (Haldol).

Review of Resident #13's care plan revealed the following concerns were identified and care-planned regarding Resident #13's behavior:

"Potential for impaired or inappropriate behaviors r/t (related to) dementia with behavioral disturbance, Alzheimer's, history of combative behavior of hitting, kicking. Date initiated 3/1/17

INTERVENTIONS
*Anticipate and address resident needs
*Approach resident in a calm manner
*Assess resident for pain and treat as indicated
*Explain procedures to resident before providing care
*Introduce self when providing care
*Labs as ordered, report results to physician
*Medications per physician orders
*Monitor for increase in behaviors or unsafe behavior and report to physician prn
*Provide calm, quiet environment during periods of agitation or violent behavior
*Psychological consult as needed
*Remove sources of agitation as possible
*Wait and reattempt when refusing care or treatment

Anti-anxiety medication used PRN for dx (diagnoses) of: anxiety
Revised 3/1/17

INTERVENTIONS
*Anti-anxiety Non-drug interventions-Monitor behavioral symptoms and side effects such as appetite changes, memory impairment, muscle weakness, sedation

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F 309	Continued From page 60 *Dose reduction attempts per evaluation if clinically indicated *Evaluate medication use and resident's response quarterly *Medication as ordered (see MAR) *Non-Drug Interventions-see behavior management care plan" While a few of the above interventions included non-pharmacological intervention (explain procedures...Introduce self...provide cal quiet environment...wait and reattempt when refusing care...) there was no evidence the staff had attempted the interventions. When interviewed, the DON stated 3/16/17 at 11:35 a.m., the staff had identified some aggressive behaviors, however there was no evidence they had attempted non-pharmacological interventions prior to administering medications. The administrator, DON, and corporate consultants were informed of the failure of the staff to identify what behaviors were appropriate for the administration of antianxiety and antipsychotic medication and to develop and implement non-pharmacological interventions prior to the administration of same medications, 3/16/17 at 11:35 a.m.	F 309		

4. The facility staff failed to follow physician orders for insulin administration for Resident #1.

Resident #1, an 85 year old female, was admitted to the facility on 6/1/2015 and readmitted on

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11/27/2016. Her diagnoses included diabetes, dementia, coronary artery disease, muscle weakness, cognitive communication deficit, osteoporosis, dysphagia, seizures, anemia, glaucoma, and hypertension.

Resident #1's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/3/2017 was coded as a quarterly assessment. She had a BIMS (Brief Interview of Mental Status) score of 6/15, indicating severe cognitive impairment. She required extensive assistance of one person for her activities of daily living and was frequently incontinent of bowel and always incontinent of bladder.

A clinical record review was conducted 3/13/2017 at 4:40 PM. It revealed a physician's order for insulin administration dated 12/5/2016 as follows:

"Humalog solution 100 units/ml (milliliter) (Insulin Lispro). Inject 5 units subcutaneously before meals. Call MD if (blood sugar readings) are less than 50 or greater than 350(milligrams per deciliter). Hold if blood sugar is less than 150."

A review of the MAR (Medication Administration Record) for Jan 2017 revealed that insulin was administered when the blood sugar reading was below 150 (milligrams per deciliter) on the following dates and times during. Blood sugar readings are in parenthesis:

1/1-8:00 AM (123), 4:30 PM (82)
1/3-8:00 AM (126), 11:30 AM (144)
1/4- 8:00 AM (136)
1/5-11:30 AM (144)
1/6-8:00 AM (136), 11:30 AM (128)
1/7-8:00 AM (140), 4:30 PM (140)

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1/8-8:00 AM (139), 11:30 AM (136)
1/9-8:00 AM (133), 11:30 AM (146), 4:30 (113)
1/10-11:30 AM (130)
1/11-8:00 AM (124), 11:30 AM (140)
1/12-11:30 AM (135)
1/13-8:00 AM (131), 4:30 PM (112)
1/14-8:00 AM (134), 11:30 AM (146)
1/15-4:30 PM (98)
1/16-11:30 AM (138)
1/17-4:30 PM (137)
1/18-8:00 AM (148), 11:30 AM (132), 4:30 PM (142)
1/19-4:30 PM (136)
1/21-11:30 AM (128)
1/22-4:30 PM (134)
1/23-11:30 AM (134), 4:30 PM (134)
1/24-4:30 PM (114)
1/25-8:00 AM (113), 11:30 AM (118)
1/26-4:30 PM (63)

On 3/16/2017 at 11:30 AM Employee B, Director of Nursing, stated that the nurses were not reviewing the entire order when administering the insulin.

Facility Policies and Procedures regarding insulin administration stated: "The clinical nurse will administer insulin subcutaneously per physician's order."

Clinical Diabetes Jan 2016 pp 25-33 published by the American Diabetes Association offered guidance regarding insulin administration as follows:

"Incorrect administration of insulin (e.g., too little, too much, or at the wrong times) can result in transient and serious hypo- and hyperglycemia, wide glycemic excursions, and diabetic

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ketoacidosis."

Administration was informed of findings on 3/16/2017 at 3:00 PM.

5. Resident #17's pain management was not provided as the physician ordered. She missed multiple doses of her Fentanyl (pain) patch.

Resident #17, a female, was admitted to the facility 8/19/14. Her diagnoses included pelvic fracture, Alzheimer's dementia, anxiety and depression.

Resident #17's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/16/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #17 was coded as having pain almost constantly with a pain level of "10" out of 10.

On 3/16/17 at 9:05 AM, Resident #17 was observed in the bed. She stated, "I hurt so bad." The medication nurse was notified of resident's complaints of pain.

Review of the clinical record, to include MAR's (medication administration record) for February and March of 2017 was conducted. The resident had a physician's order dated 3/18/16 for Fentanyl patch every 72 hours. Fentanyl is an opioid, schedule II narcotic used to treat chronic pain. Dates and times the medication was not

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given as it was not available are below:

2/5/17 at 1:00 PM: coded as a "9" or see nurses notes. Nurses notes dated 2/5/17 included: Resident's medication is on afternoon run from the pharmacy." Her pain score was left blank and no documentation was evident the patch had been applied. Tylenol 650 mg (milligrams) was given at 6:00 PM with a pain score of "8". At 7:00 PM, the nurses note read, "prn (as needed) pain medication was ineffective." Pain scale was still "8". At 8:38 PM, Norco 5/325 mg one tablet was given with relief and a pain scale of "2" an hour later. The Fentanyl patch was documented as given on 2/7/17 at 9:50 AM.

3/5/17 at 7:58 PM: "no patch available old patch left on." Pain level was scored as a "10". No patch was documented as given until 3/8/17 at 9:36 PM. No pain medication was given until 3/6/17 at 9:23 PM, which the pain level was documented as "7" and Norco 7.5/325 mg pill was given.

On 3/16/17 at 12:07 PM, an interview was conducted with the DON (director of nursing). She described the procedure for obtaining narcotics when not available. She stated, "We call the pharmacy. We may need to call the physician for a script (prescription)."

Review of the policy on Pain Management included the following: "Unrelieved pain has negative physical and psychological consequences, including the potential for threatening functional ability."

On 3/16/17 at 12:10 PM, the Administrator and DON were notified of above findings.

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F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. 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 protect the resident population from biohazardous waste, and used syringes/needles, and also failed to supervise/monitor one Resident on elopement protocol (Resident #6) in a survey sample of 24 residents. 1. The biohazard closet was open and available	F 323	1. A) Biohazard door has a new lock on it that is secured to prevent anyone from opening it without a key. All Biohazard waste, recepticals and sharp articles are put up properly in biohazard containers and removed per protocol. B) Resident #6's wandergard was checked and it works properly. 2. A) All biohazard doors in the facility have the potential to be affected. B) All residents with wandergards have potential to be affected. 3. A) All housekeeping staff and licensed nursing staff will be in-serviced on making sure the biohazard doors are securely locked when closing the door and hazards associated with blood borne pathogens in biohazard closets. B) Licensed nurses and Customer Care Liaison (CCL) (AKA Manager on Duty) will be re-educated on monitor wanderguard and document the outcome per policy.	04/18/2017

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F 323	Continued From page 66 to Residents who were wandering unsupervised in the hallway. The closet contained, scattered on the floor, and sitting on top of red biohazardous waste receptacles, multiple forms of biohazardous waste, and used sharp articles that would be an infection control and injury hazard to the resident population. 2. Resident #6's wandergard bracelet was not monitored for placement and function as ordered, and per policy multiple times, and the biohazardous waste closet was open and able to be accessed by this confused Resident. The findings included: 1. On 3-14-17 during initial tour of the facility at 2:15 p.m., with the Director of Nursing (DON), the biohazard closet was found to be open and unlocked. Nursing staff members were at the end of the hallway and around a corner in the nursing station, not in view of the biohazard closet, nor able to view the residents on that hallway. Multiple residents were wandering in the hallway unsupervised entering different rooms, to include Resident #6, who was found to be confused, agitated, ambulatory, and was walking aimlessly into rooms, opening doors, and leaving her rolling walker in the hallway, as she forgot to use it at times. Resident #6 was entered into the survey sample. Upon opening the door fully to expose it's contents, the following was found scattered on the floor and sitting on red biohazardous waste bins; Blood borne pathogen contaminated used needles, (4) overflowing used sharps containers, filled with used needles, blood filled IV tubing, medications, etc. Also in the room scattered on	F 323	4. A) The DCS/designee will monitor biohazard doors and biohazard waste disposal audits on the doors being securely locked and biohazard waste disposed properly 4xs a week for 30 days, then 2xs a week for 30 days. B) Unit Managers and CCL will audit wanderguard check and documentations 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	

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the floor and in the open waste bins were used and visibly soiled gloves, used glass insulin medication vials, (3) soiled red infection control isolation waste and linen cans (2 metal, and 1 plastic), Intravenous blood drawing tubing and vacutainers with needles affixed to them, and filled with blood, used fingerstick blood sugar testing lancets, used shaving razors, broken glass, and (1) large red bin trash can with (5) vials of used injectable insulin which still contained some medication in them, and a visibly soiled wet hand towel. None of the waste containers had red bag liners in them for closed containment of the biohazardous materials. The closet had a strong, foul human waste odor, which could be detected in the hallway outside of the room.

The DON (Director of Nursing) immediately called for staff to help, and stated that this room should always be locked. The lock on the door was a numbered punch button electronic lock, and it was inoperable, and could not be locked. A maintenance department employee came to the room and removed 3 of the 4 sharps containers, and stated that he would box them and remove them to the outside of the building in a storage area to be picked up for incineration, and the DON went with him. The fourth sharps container was left in the room, with the other items. The room door was closed, however, could not be locked, and the surveyor stood there alone to observe the room. Resident #6 remained as did other residents in the hallway wandering. At 2:45 p.m. the Maintenance director came to the room and inspected the inoperable door lock, and stated this is broken, and I will have to replace it; no one told me it was broken. When asked how long the door lock had been inoperable, staff

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stated they did not know. At 2:45 p.m. a second and a third surveyor joined the observation. The maintenance director left the area to obtain a new door handle and lock. At 3:00 p.m. the maintenance director returned and fixed the lock, and locked the door.

The next morning on 3-15-17 at 9:00 a.m., the door to the biohazard closet was checked and found to be open/unlocked again. All of the items found the previous day were found in the closet, except for the 3 sharps containers which were removed on the first observation, however, the fourth sharps container which was full to overflowing also, still remained in the closet. The Corporate Registered Nurse (RN) Employee G Consultant observed the surveyor check the door, and immediately came to the room, and checked the door which had been unlocked from the inside by staff, and was left open, and unlocked. Resident #6 and other residents were again in the hallway wandering. The maintenance director was again called to the area, and changed the lock again, to one that could not be left unlocked, and could only be accessed with a key.

The Corporate RN stated that the staff would be counseled and educated immediately on the hazards associated with blood borne pathogens in the biohazard closet, and to emphasize the importance of it always remaining locked.

Review of the facility infection control program policies revealed that The Centers for Disease Control (CDC) standards would be followed. CDC standards require that all contaminated biohazardous waste, and blood borne pathogens must be contained in an inaccessible area to prevent the spread of infection.

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The facility Administration was made aware of the issue on 3-15-17, and 3-16-17 at the end of day debriefings, and no further information was available to be provided by the facility.

2. Resident #6's wandergard bracelet was not monitored for placement and function as ordered, and per policy multiple times, and the biohazardous waste closet was open and able to be accessed by this confused Resident.

Resident #6, was admitted to the facility on 2-9-17. Diagnoses included; Vascular dementia with behavioral disturbance, anemia, altered mental status, chronic kidney disease, hypertension, diabetes, and high cholesterol.

Resident #6's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2-16-17 was coded as an admission assessment. Resident #6 was coded as having a BIMS (brief interview of mental status) score of "8" out of a possible 15, or moderate cognitive impairment. Resident #6 was also coded as having behaviors 1-3 days of the 7 day look back period not directed at others to include pacing, rummaging, throwing or smearing food or bodily waste. The Resident was coded as needing supervision only for ambulation. The Resident was coded as frequently incontinent of bowel and bladder, and wore adult incontinence briefs.

Review of the Residents care plan revealed a "Focus" for "Potential for impaired or

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inappropriate behaviors R/T (related to) history of disruptive/aggressive behaviors at home, history of wandering at home. Cognitive loss- R/T vascular dementia and psychotropic drug use. "Resident seeks areas other than bathroom for toileting needs." "Goals" included; "Resident will not demonstrate violence toward others or self, Resident will not exit the facility unattended." "Interventions" included, "Check exit door alarms daily, elopement risk assessment, Monitor for increase in behaviors or unsafe behaviors and report to physician as needed, monitor for bathroom seeking behaviors and offer redirection and assistance as needed, wandergard bracelet per doctor's order, check function and placement every shift and as needed."

Review of Medication, and Treatment Administration records (MAR's &TAR's) revealed that no monitoring of the Resident's wandergard bracelet was conducted on 2-26-17 during the evening shift (3:00 p.m., to 11:00 p.m.), 3-1-17 during the evening shift, nor on 3-13-17 during the evening shift.

The Administrator stated on 3-15-17 at 5:00 p.m., at the end of day debrief, that the Manager on Duty (MOD) also checked wandergard functioning during the day shift every day, and those days in question might be documented on those forms. The documents were retrieved and showed that the MOD daily checks were not completed for Resident #6 on; 3-1-17, 3-2-17, 3-3-17, 3-4-17, 3-5-17, 3-6-17, 3-7-17, 3-12-17, 3-13-17, and 3-15-17.

On 3-14-17 at 2:10 p.m., Resident #6 was observed prior to initial tour, in the hallway of the biohazardous waste closet, ambulating without

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F 323	Continued From page 71 her rolling walker which she had left in front of the nursing station, as stated by staff later, after the observation. The Resident was entering other resident's rooms, opening doors along the hallway, and seemingly searching for something or someone. When the Resident was approached by the surveyor, and asked if she was looking for something, she stated "Yes, I can't find sh.. !(cursing expletive), and she moved on to the next door and opened it. Staff did not intervene, and were not present on the hallway, however, multiple other residents were in the hallway, some sitting stationary in wheel chairs, others self propelling in wheel chairs. On 3-15-17 at 9:00 a.m., Resident #6 was again observed wandering in the hallway of the biohazardous waste closet ambulating without her rolling walker, exhibiting the same searching behavior that was seen the day before. When spoken to, the Resident began talking about a "little boy" in the hallway "making a racket", and that someone should make him be quiet. There was no child of either gender in the hallway. The facility policy on elopement stated that wandergard bracelets would be checked for placement and functioning every shift. The facility Administration was made aware of the issues of not monitoring the wandergard bracelet for Resident #6, and the open biohazardous waste closet, which could have been accessed by Resident #6, and others on 3-15-17, and 3-16-17 at the end of day debriefings. No further information was available to be provided by the facility.	F 323		
F 329	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE	F 329		

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F 329 SS=D	Continued From page 72 FROM UNNECESSARY DRUGS 483.45(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 (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. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in	F 329	1. Physician was notified of resident #1 receiving insulin when she was below her parameters. Resident has new order set implemented to alert license nurse to check parameters prior to administering insulin. No adverse effects noted from insulin being given outside of parameters. 2. Residents with the diagnosis of diabetes and receive insulin with parameters have the potential to be affected.	04/18/2017

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F 329	Continued From page 73 an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to ensure that unnecessary medications were not administered to one Resident (#1). The facility staff administered insulin to Resident #1 when it was not required per physician's order. The findings included: Resident #1, an 85 year old female, was admitted to the facility on 6/1/2015 and readmitted on 11/27/2016. Her diagnoses included diabetes, dementia, coronary artery disease, muscle weakness, cognitive communication deficit, osteoporosis, dysphagia, seizures, anemia, glaucoma, and hypertension. Resident #1's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/3/2017 was coded as a quarterly assessment. She had a BIMS (Brief Interview of Mental Status) score of 6/15, indicating severe cognitive impairment. She required extensive assistance of one person for her activities of daily living and was frequently incontinent of bowel and always incontinent of bladder. A clinical record review was conducted 3/13/2017 at 4:40 PM. It revealed a physician's order for insulin administration dated 12/5/2016 as follows: "Humalog solution 100 units/ml (milliliter) (Insulin Lispro). Inject 5 units subcutaneously before meals. Call MD if (blood sugar readings) are less than 50 or greater than 350. Hold if blood sugar	F 329	3. An audit will be completed on residents who receive insulin with blood glucose parameters. These residents orders will be updated with new standing orders to alert nurses to check for parameters prior to administrating insulin. The nursing staff will receive education on effective insulin management. If current order is not controlling blood glucose, license nurse will notify MD. Licensed nursing staff will be in-serviced when entering new insulin orders with parameters to choose the new batch order for insulin, which allows parameters to be entered. This will alert nursing staff to check parameters before administering insulin. Licensed staff will complete medication administration quiz to validate competency.	

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F 329	Continued From page 74 is less than 150." A review of the MAR (Medication Administration Record) for Jan 2017 revealed that insulin was administered when the blood sugar reading was below 150 on the following dates and times during. Blood sugar readings are in parenthesis: 1/1-8:00 AM (123), 4:30 PM (82) 1/3-8:00 AM (126), 11:30 AM (144) 1/4- 8:00 AM (136) 1/5-11:30 AM (144) 1/6-8:00 AM (136), 11:30 AM (128) 1/7-8:00 AM (140), 4:30 PM (140) 1/8-8:00 AM (139), 11:30 AM (136) 1/9-8:00 AM (133), 11:30 AM (146), 4:30 (113) 1/10-11:30 AM (130) 1/11-8:00 AM (124), 11:30 AM (140) 1/12-11:30 AM (135) 1/13-8:00 AM (131), 4:30 PM (112) 1/14-8:00 AM (134), 11:30 AM (146) 1/15-4:30 PM (98) 1/16-11:30 AM (138) 1/17-4:30 PM (137) 1/18-8:00 AM (148), 11:30 AM (132), 4:30 PM (142) 1/19-4:30 PM (136) 1/21-11:30 AM (128) 1/22-4:30 PM (134) 1/23-11:30 AM (134), 4:30 PM (134) 1/24-4:30 PM (114) 1/25-8:00 AM (113), 11:30 AM (118) 1/26-4:30 PM (63) On 3/16/2017 at 11:30 AM Employee B, Director of Nursing, stated that the nurses were not reviewing the entire order when administering the insulin.	F 329	4. The DCS/designee will audit random blood glucose levels 4xs a week for 30 days, then 2xs a week for 30 days to determine if current order is effective diabetic management and MD is notified when indicated. SDC will complete random observation audits on insulin administration 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/17	

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F 329	Continued From page 75 Facility Policies and Procedures regarding insulin administration stated: "The clinical nurse will administer insulin subcutaneously per physician's order." Clinical Diabetes Jan 2016 pp 25-33 published by the American Diabetes Association offered guidance regarding insulin administration as follows: "Incorrect administration of insulin (e.g., too little, too much, or at the wrong times) can result in transient and serious hypo- and hyperglycemia, wide glycemic excursions, and diabetic ketoacidosis." Administration was informed of findings on 3/16/2017 at 3:00 PM.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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	F 371	1. Dietary manager discarded the contaminated pureed pasta and substituted with another item for puree starch. The soiled mitt was discarded. Employee N has been in serviced on food handling to prevent contamination. 2. All residents have potential to be affected. 3. Dietary manager or designee will in service dietary staff on food handling to prevent contamination.	04/18/2017

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F 371	Continued From page 76 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. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to prepare food in accordance with professional standards for food service safety. The facility staff failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. The facility staff contaminated food with a heavily soiled oven mitt. The Findings included: On 3/15/17 at 11:20 A.M. an observation was conducted in the kitchen of the trayline for lunch service. The facility cook (Employee N) was wearing oven mitts that were heavily soiled with black and brown substances. She was observed removing a metal container of pureed pasta from the oven and placing it on the steam table. Approximately one-third of the container was not fully covered with plastic wrap. The cook submerged the soiled oven mitt into the food, coating the oven mitt with pureed white colored pasta. She then used a spoon to place the contaminated pasta on a residents plate, the plate was covered by another staff member and placed on the cart to be sent to the dining room. The Dietary Manager (Employee M) was present during the kitchen observation. She stated that	F 371	4. Dietary manager or designee will monitor one meal 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	

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F 371	Continued From page 77 she identified the substance on the oven mitt as being pureed pasta. On 3/16/17 at 12 Noon, the facility Administrator was informed of the findings. She stated that after the surveyor left the kitchen, the contaminated food had been discarded.	F 371		
F 372 SS=E	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, the facility staff failed to ensure the dumpster doors and lids were kept closed. During General Observations Tour of the facility, three of four dumpsters were not closed properly. Findings included: A General Observations of the Facility Tour was conducted on 3/16/2017 at approximately 9:45 AM with the Maintenance Director (Employee F) and Housekeeping Director (Employee P). On the left of the building, one dumpster with no cover or lid was observed. Several old mattresses, broken beds, old chairs were observed inside. The dumpster was numbered as #3202. The Maintenance Director stated that dumpster was a construction dumpster and no chemicals and no dietary foods were placed in that dumpster. On the right side of the building, there were 3 dumpsters, 2 of the 3 were not closed properly.	F 372	1. The dumpster on the left side of the building has been removed by the contractor. The dumpster on the right side of the building with a half lid on top has been replaced with a new one. The dietary employee was in-serviced on keeping the dumpsters lids/doors closed and infection control. 2. All residents have the potential to be affected. 3. Executive Director or designee will re-educate maintenance, environmental and dietary staff on keep the dumpster's lids/doors closed at all time. 4. Maintenance staff will monitor the dumpsters 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	04/18/2017

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F 372	Continued From page 78	F 372		

One was marked as a 6 yard dumpster and only had a half lid on top. Another dumpster marked as "8 yd BR 45-776" had the side doors open and the top lid was flipped back and uncovered.

Maintenance Director (Employee F) stated the Maintenance department was informed that the top was broken on one of the dumpsters. Employee F stated it must have happened during pick up on Friday or Saturday of the previous week. Employee F stated he had contacted the company "CASS Information Systems" on Monday 3/13/17 and reported the need to have the dumpster repaired. Employee F stated he was waiting for a response.

During the General Observations tour outside with Employee F, the Dietary staff cook (Employee L) was observed pushing a trash can full of trash toward the dumpsters to the right of the facility. Observed Employee L throwing trash into the dumpster through the slot near the top. Employee L was observed pushing the emptied trash can back toward the kitchen door. The dumpster door was still open and the top lid was not closed. Employee F stated the dumpster was open when Employee L approached it but Employee L should have closed the door and lid of the dumpster after using it. Employee F stated all staff members were expected to make sure the dumpster doors and lids were kept closed.

Interview with the Dietary Services manager who stated all staff had been instructed to keep the dumpster doors and lids closed at all times. The Dietary Services Manager (Employee M) stated she submitted a maintenance repair slip the previous week to report that a new top was

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F 372	Continued From page 79 needed for one of the dumpsters. Employee M presented a copy of the Maintenance Repair Requisition dated 3/8/17 which stated "Item in need of repair: Dumpster top off" and "Problem: Need a top." Employee M stated she was waiting for the dumpster to be repaired. Employee F presented a copy of an email dated 3/16/2017 at 11:33 AM from the CASS company which stated "the lids will be on the containers on 3-17." The email indicated Employee F had contacted the company on Monday 3/13/17 and "left a message for this to be completed as soon as possible." During the end of day debriefing, the facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings. No further information was provided.	F 372		
F 386 SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 386	1. All Physician Progress Notes for Resident # 3 have been signed and dated, by the resident's Physician. 2. All residents within the facility have the potential to be affected. 3. The ED/Designee, will in-service the Physicians, on signing and dating progress notes after each visit.	04/18/2017

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F 386	Continued From page 80 by: Based on clinical record review and staff interview, the facility staff failed to ensure the physician signed his progress notes for one Resident (Resident #3) in a survey sample of 24 Residents. EMP Q, the physician, failed to sign progress notes for Resident #3 on 9/28/16, 10/12/16, 11/28/16, and 1/18/16. The findings included: Resident #3, a male, was admitted to the facility 8/16/16. His diagnoses included atrial fibrillation, Alzheimer's dementia, and cognitive communication deficit. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/7/17 was coded as a quarterly assessment. Resident #3 was coded as having long and short term memory deficits and required total assistance with making daily life decisions. Resident #3 was coded as needing limited to total assistance of one to two staff members to perform his activities of daily living. Review of Resident #3's clinical record revealed Resident #3's physician completed progress notes on 9/28/16, 10/12/16, 11/28/16 and 1/18/16. Review of the notes revealed none of the notes were electronically or ink signed. An entry on the notes included, "Not signed." EMP Q stated 3/15/17 at 10:18 a.m., he completed the progress notes after the visit and sent the notes to the facility from his office.	F 386	4. Medical Records/Designee will monitor progress notes, to ensure they are signed, and dated with audits of Physician Progress Notes 4x/week for 30 days, then 2x/week for 30 days. The results will be presented to QAPI for review and recommendations. 5. 04/18/2017	

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F 386	Continued From page 81 The DON (director of nursing) stated 3/15/17 at 11:52 a.m. "Dr (EMP Q's name) types up the notes but didn't sign them..." The administrator, DON, and corporate consultants were informed of the failure of EMP Q to sign progress notes for Resident #3, 3/16/17 at 11:35 a.m.	F 386		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced	F 412	1. Resident #7 dental consult was discontinued by MD due to him not being a good candidate. 2. All residents with dental consults have the potential to be affected. 3. An audit on all residents' orders for dental consults will be conducted to ensure that they were completed. Licensed nursing staff will be in-serviced on how to input consult orders so the order is not indefinite, but a one time order. The order will be completed once the appointment is made. 4. The DCS/designee will audit orders for consult orders and make sure they are entered correctly 4xs a week for 30days, then 2xs a week for 30days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/2017	04/18/2017

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F 412	Continued From page 82	F 412		

by:
Based on observation, staff interview, and clinical record review, the facility staff failed to provide physician ordered dental care for one Resident (Resident #7) in a survey sample of 24 Residents.

The physician ordered 11/2/16 for Resident #7 to be evaluated by an oral surgeon. As of the end of the survey 3/16/17 at 3:15 p.m., Resident #7 had not been evaluated by an oral surgeon.

Resident #7, a male, was initially admitted to the facility 3/2/01. His diagnoses included aphasia, type II diabetes mellitus, hemiplegia, monoarthritis, vascular dementia with behavioral disturbances, hypothyroidism, hyperlipidemia, osteoporosis, major depressive disorder, hypertension, seizures, and iron deficiency anemia.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/17/16 was coded as a quarterly assessment with a subsequent modification. Resident #7 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as requiring extensive to total assistance of one to two staff members to perform his activities of daily living.

Resident #7 was observed 3/14/17 at 4:08 p.m. He was lying on his back, awake and alert. Resident #7's mouth was open and only four teeth were observed. Resident #7 was receiving incontinence care.

Review of Resident #7's clinical record revealed a

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F 412	Continued From page 83 signed physician's order, "11/2/16 Oral Surgical Consult." The order had been obtained as a verbal order and a thorough review of the nursing progress notes failed to review why Resident #7 was ordered to see an oral surgeon. Additionally, no oral surgical consult was evident within Resident #7's clinical record. When interviewed, 3/16/17 at 11:35 a.m., the DON (director of nursing) stated the staff had noticed Resident #7 had bad breath and felt he needed to see "someone for that." The physician had been contacted and gave the order for Resident #7 to be seen by the oral surgeon. After the order was obtained, "the staff figured he would not tolerate sitting in the dental chair" and decided not to pursue Resident #7 seeing an oral surgeon. No evidence was apparent that Resident #7's physician had been informed that he would not tolerate seeing an oral surgeon and the order was still active on the recapitulation of Resident #7's care and medications. Guidance for nursing practice for following physician's orders was included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." The administrator, DON, and corporate consultants were informed of the failure of the staff to ensure Resident #7 was evaluated by an oral surgeon per physician's orders, 3/16/17 at 11:35 a.m.	F 412		
F 425	483.45(a)(b)(1) PHARMACEUTICAL SVC -	F 425		

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F 425 SS=E	Continued From page 84 ACCURATE PROCEDURES, RPH (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-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to ensure medications were available for administration for five Residents (Residents' #5, #7, #14, #17 and #8) in a survey sample of 24 Residents. 1. For Resident #5, Clozapine (an antipsychotic medication) was not available for administration; 2. For Resident #7, Hydrophor ointment (a medicated ointment) was not available for administration on 12/17/16 on 3-11 shift; 3. For Resident # 14, the facility staff failed to ensure the medication Cyanocobalamin (Vitamin B 12) injection was available for administration. Cyanocobalamin, a medication used for the treatment of Vitamin B-12 deficiency, was documented as not administered and unavailable for administration on 10/23/2016, 11/23/2016 and 12/23/2016;	F 425	1. Resident #5 Clozapine is available to administer as ordered. Physician was notified of omitted administration occurrences. Resident #5 Clozapine has been administered since 9/1/17. No adverse effects noted from omission of administration. Resident #7 Hydrophor ointment is available to administer as ordered. Physician was notified of omitted occurrence. No adverse effects noted from omission of medication administration. Resident #14 Cyanocobalamin injection is available to administer as ordered. Physician notified of omitted occurrences. No adverse effects noted from omission of medication administration.	04/18/2017

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F 425	Continued From page 85 4. Resident #17's Fentanyl patch was not available for use; and 5. For Resident #8, the facility staff failed to ensure the physician ordered pain medication (Percocet) and antianxiety medication (Clonazepam) were available for administration. The findings included: 1. For Resident #5, Clozapine (an antipsychotic medication) was not available for administration. Resident #5, a male, was admitted to the facility 2/9/16 and readmitted after a hospitalization 8/29/16. His diagnoses included chronic obstructive pulmonary disease, muscle weakness, schizoaffective disorder, hypercholesterolemia, anorexia nervousa, delirium, hypertension, benign prostatic hypertrophy, gastroesophageal reflux disease, type II diabetes mellitus, and dysphagia. Resident #5's most recent MDS (minimum data set) with and ARD (assessment reference date) of 3/1/17 was coded as a quarterly assessment. Resident #5 was coded as having no memory deficits and was able to make his own daily life decisions. Resident #5 was coded as requiring no assistance with his activities of daily living with the exception eating and bathing. For eating and bathing, he was coded as requiring standby assistance. Review of Resident #5's clinical record revealed he had been hospitalized from 6/28/16 to 8/29/16 due to a rapid decline of mental stability and excessive delirium including delusions, hallucinations, and behaviors. Upon returning to	F 425	Resident #17 Fentanyl patch was discontinued with new pain management in place. Physician was notified of omitted occurrence. No adverse effects noted from omission of medication administration. Pain assessment completed on 4/5/17. Resident # 8 Percocet and Clonazepam is available to administer as ordered. Physician was notified of omitted occurrences. No adverse effects noted from omission of medication administration. Pain assessment completed on 3/15/17. 2. Residents receiving orders for medications from pharmacy and over the counter medications have the potential to be affected 3. Licensed nursing staff will be re-educated on the policy for reordering medications from the pharmacy. Nursing staff will be re-educated on stat box usage.	

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F 425	Continued From page 86 the facility, included with his readmission physician order was, "8/29/16 Clozaril (Clozapine) 150 mg (milligram) PO (by mouth) BID (twice daily)." An accompanying entry was placed on the eMAR (electronic medication administration record). "5, 9, or H" were entered into the area indicating Clozaril 150 mg was not administered on 8/29 at 5 p.m. through 5 p.m. on 8/31/17 (5 doses). www.drugs.com indicated: "Clozapine is an antipsychotic medication. It works by changing the actions of chemicals in the brain. Clozapine is used to treat severe schizophrenia, or to reduce the risk of suicidal behavior in people with schizophrenia or similar disorders. Clozapine is available only from a certified pharmacy under a special program. You must be registered in the program and agree to undergo frequent blood tests." Documentation revealed Resident #5 was on Clozaril prior to requiring hospitalization and the medication had not been available at the time of his discharge to the acute psychiatric hospital in June, 2016. Resident #5 had also been on the medication while hospitalized at the acute psychiatric facility, prior to returning to the facility 8/29/16. When interviewed, the DON (director of nursing) stated 3/16/17 at 11:35 a.m., Clozaril was not available as the medication required Resident #5 to be enrolled in a special medication program due to the severity of side effects.	F 425	4. The DCS/designee will monitor medication administration for residents with MAR documentation and over the counter medications availability 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/17	

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The administrator, DON, and corporate consultants were informed of the failure of the staff to ensure Clozaril was available for administration to Resident #5 8/29-31/16, on 3/16/17 at 11:35 a.m.

2. For Resident #7, Hydrophor ointment (a protective ointment) was not available for administration 12/17/16 on 3-11 shift.

Resident #7, a male, was initially admitted to the facility 3/2/01. His diagnoses included aphasia, type II diabetes mellitus, hemiplegia, monoarthritis, vascular dementia with behavioral disturbances, hypothyroidism, hyperlipidemia, osteoporosis, major depressive disorder, hypertension, seizures, and iron deficiency anemia.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/17/16 was coded as a quarterly assessment with a subsequent modification. Resident #7 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as requiring extensive to total assistance of one two staff members to perform his activities of daily living.

Review of Resident #7's clinical record revealed "Hydrophor" was not administered per physician's order 1/12/17 on 3-11 shift. Hydrophor was a protective ointment to be applied every shift and after incontinent episodes. An entry was on the eTAR (electronic treatment administration record) indicating the ointment was not administered and referred the reader to the nursing progress notes.

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Within the nursing progress notes, was an entry indicating the ointment was not available.

When interviewed 3/16/17 at 11:35 a.m., the DON (director of nursing) stated she was unsure why the ointment was not available as it was a "stock" product. As of the end of the survey, no further information was provided.

The administrator, DON, and corporate consultants were advised of the failure of the staff to administer Hydrophor ointment to Resident #7 on 1/12/17 3-11 shift, per physician's order, 3/16/17 at 11:35 a.m.

3. For Resident # 14, the facility staff failed to ensure the medication Cyanocobalamin (Vitamin B 12) injection was available for administration. Cyanocobalamin, a medication used for the treatment of Vitamin B-12 deficiency, was documented as not administered and unavailable for administration on 10/23/2016, 11/23/2016 and 12/23/2016.

Resident #14 was originally admitted to the facility on 8/13/2007 and readmitted on 12/2/2015 with the diagnoses of, but not limited to, Diabetes, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Major Depressive Disorder, Carcinoma in Situ, Malignant Neoplasm of Ovary, Endometrial Cancer, Acute Embolism and Thrombosis of Deep Veins.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/14/17. The MDS coded Resident # 14 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive

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impairment; Resident # 14 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living; required set up only for eating; and always continent of bowel and frequently incontinent of bladder.

On 3/15/17 at 9 a.m., Resident #14's clinical record was reviewed. The review revealed a physician's order dated 9/30/2016 which read: Cyanocobalamin (Vitamin B-12) 1000 mcg/ml (1000 micrograms per milliliter) inject one milliliter subcutaneously once every month.

The order was transcribed on the October 2016 Medication Administration Record (MAR), on page 2, as ordered to be administered at 6 A.M. on the 23 rd of each month. Review of the October 2016 MAR revealed the number "5" and the nurse's initials for 10/23/16. On the bottom of the page of the MAR under the "Chart Codes/Follow Up Codes" section was listed "5=Hold/See Nurse Notes."

Review of the Interdisciplinary Notes revealed documentation on 10/23/2016 at 6:28 AM of "Medication Administration Note: Placed on hold until delivered from pharmacy. STAT refill requested and faxed to received today." (sic)

The next Interdisciplinary Note was 10/23/2016 at 6:30 AM Nursing Note: "ordered STAT Cyanocobalamin from pharmacy so that resident can receive injection today as scheduled."

Review of the November 2016 MAR, on Page 2, revealed the number "9" and the nurse's initials for 11/23/16. On the bottom of the page of the MAR under the "Chart Codes/Follow Up Codes" section was listed "9=Other/See Nurse Notes."

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Review of the December 2016 MAR, on Page 2, revealed the number "5" and the nurse's initials for 12/23/16. On the bottom of the page of the MAR under the "Chart Codes/Follow Up Codes" section was listed "5=Hold/See Nurse Notes."

Review of the Interdisciplinary Notes revealed documentation on 11/23/2016 at 6:28 AM of "Medication Administration Note: Placed on hold until delivered from pharmacy. STAT refill requested and faxed to received today." (sic)

The Medication Administration Note dated 12/23/2016 at 6:04 AM Nursing Note: "order on hold until md (medical doctor) clarification."

Further review of the October, November and December 2016 MARs and Nursing Progress Notes revealed no documentation of Administration of the medication.

On 3/15/2017 at 4 PM, an interview was conducted with the Director of Nursing (DON) who stated she would investigate to determine if Resident # 14 received the medication as ordered by the physician. The Director of Nursing stated the expectation was that medications should be available for administration as ordered by the physician. The Director of Nursing stated the nurse should call the pharmacy immediately to request a medication that is not available at the scheduled time of administration. The emergency (STAT) box medication list was requested.

On 3/16/17 at 10:50 a.m. an interview was conducted with the Director of Nursing who stated she had checked the documentation in the

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computer and with Pharmacy and determined that the medication was delivered by the pharmacy but was not administered on 10/23/2016. The DON stated the Pharmacy made routine deliveries two times per day and STAT deliveries. The DON presented a copy of the Pharmacy Shipment Summary for 10/23/016 which documented Cyanocobalamin B-12 Injection 1000 mcg/1 ml vial was picked up on 10/23/2016 at 8:54 PM and delivered on 10/24/2016 at 12:33 AM. The DON again stated the medication was not administered. The Director of Nursing stated the expectation was that medications should be administered as ordered by the physician.

During the end of day debriefing on 3/16/2017 at 11:10 a.m., the facility Administrator and Director of Nursing were informed of the findings.

The facility staff did not present any further information regarding the findings.

4. Resident #17's Fentanyl patch was not available for use.

Resident #17, a female, was admitted to the facility 8/19/14. Her diagnoses included pelvic fracture, Alzheimer's dementia, anxiety and depression.

Resident #17's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/16/16 was coded as a quarterly assessment. She was coded as having short and long term

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memory deficits and required total assistance with making daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #17 was coded as having pain almost constantly with a pain level of "10" out of 10.

On 3/16/17 at 9:05 AM, Resident #17 was observed in the bed. She stated, "I hurt so bad." The medication nurse was notified of resident's complaints of pain.

Review of the clinical record, to include MAR's (medication administration record) for February and March of 2017 was conducted. The resident had a physician's order dated 3/18/16 for Fentanyl patch every 72 hours. Fentanyl is an opioid, schedule II narcotic used to treat chronic pain. Dates and times the medication was not given as it was not available are below:

2/5/17 at 1:00 PM: coded as a "9" or see nurses notes. Nurses notes dated 2/5/17 included: Resident's medication is on afternoon run from the pharmacy." Her pain score was left blank and no documentation was evident the patch had been applied. Tylenol 650 mg (milligrams) was given at 6:00 PM with a pain score of "8". At 7:00 PM, the nurses note read, "prn (as needed) pain medication was ineffective." Pain scale was still "8". At 8:38 PM, Norco 5/325 mg one tablet was given with relief and a pain scale of "2" an hour later. The Fentanyl patch was documented as given on 2/7/17 at 9:50 AM.

3/5/17 at 7:58 PM: "no patch available old patch left on." Pain level was scored as a "10". No patch was documented as given until 3/8/17 at

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9:36 PM. No pain medication was given until 3/6/17 at 9:23 PM, which the pain level was documented as "7" and Norco 7.5/325 mg pill was given.

On 3/16/17 at 12:07 PM, an interview was conducted with the DON (director of nursing). She described the procedure for obtaining narcotics when not available. She stated, "We call the pharmacy. We may need to call the physician for a script (prescription)."

Review of the policy on Pain Management included the following: "Unrelieved pain has negative physical and psychological consequences, including the potential for threatening functional ability."

On 3/16/17 at 12:10 PM, the Administrator and DON were notified of above findings.

5. For Resident #8, the facility staff failed to ensure the physician ordered pain medication (Percocet) and antianxiety medication (Clonazepam) were available for administration.

Resident #8 was admitted to the facility on 4/20/15 with the diagnoses of, but not limited to, spinal stenosis, osteoarthritis, lower back pain and anxiety.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/16/16. The MDS coded Resident #8 with no cognitive impairment; required set up to no assistance with activities of daily living; was continent of bowel and bladder;

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and had occasional pain with an average pain scale of 4 (out of 10).

On 3/14/17 at 2:25 p.m., Resident #8 was observed in her room sitting in a lounge chair with 2 visitors exiting the room. She was alert and talkative. A Resident interview was conducted and when asked about physician visits, she stated she has seen her doctor and "He ordered me pain medication but I don't think I've had my medicine for anxiety ordered yet" Resident #8 did not complain of pain nor show signs of anxiety.

On 3/15/17 at 8:50 a.m. Resident #8's clinical record was reviewed. The review revealed pain assessments were completed each shift for the months of February and March 2017. Physician orders were reviewed and revealed the following medications for pain management:

Oxycodone-Acetaminophen (Percocet) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 8 hours for Pain,
Voltaren Gel 1 % (Diclofenac Sodium) Apply 4 gram transdermally as needed for Pain apply to elbows and knees as needed 4 x daily,
Mapap Tablet 325 mg (Acetaminophen) Give 2 tablets by mouth every 4 hours as needed for Pain.

Resident #8's Medication Administration Record (MAR) for the months of February and March 2017 were reviewed. The review revealed the Percocet was administered as ordered throughout the month of February and the as needed (PRN) Mapap was administered on 3 occasions (2/11, 2/24 & 2/25/17).

Review of March 2017's MAR revealed the

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following:

The Percocet was administered as ordered 3/1-3/11 at 6 a.m., 2 p.m. and 10 p.m. From 3/12/17 at 10 p.m. through 3/14/17 at 10 p.m. the medication was documented as "9=Other/See Nurse Notes." Review of the Progress Notes for the corresponding dates had documentation that read "Not available awaiting pharmacy to deliver." There was no documentation that the pharmacy or physician were called.

Resident #8 received PRN Mapap for complaints of back pain or headache on 3/9/17 at 11 p.m., 3/11 at 9:06 p.m., 3/12 at 9:28 p.m., 3/13 at 4:38 p.m. and 3/14/17 at 6:11 a.m. The PRN pain medication was documented as effective.

Further review of the physician's orders revealed the medication Clonazepam 0.5 mg Give 1 tablet by mouth every 12 hours for for(sic) anxiety was ordered on 10/5/16. The MAR for February 2017 revealed the Clonazepam was scheduled for administration at 9 a.m. and 9 p.m. and was initialed by the nurses as administered. The MAR for March 2017 revealed the Clonazepam was not administered as ordered on 3/8, 3/9, 3/10, 3/12, 3/13 and 3/14/17 at 9 p.m. and 3/10, 3/11, 3/12, 3/13 and 3/14 at 9 a.m. Documentation on the MAR read either "5=Hold/See Nurse Notes" or "9=Other/See Nurse Notes." The nurses notes included "med not in house," "med put on hold by md until available," and on 3/14/17 at 10:24 p.m. "not available needs new script. Patient aware"

On 3/15/17 at 2:45 p.m. an interview was conducted with Licensed Practical Nurse-B (LPN-B). LPN-B showed surveyor upon request the blisterpack (medication package) containing

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Resident #8's percocet. The processing date on the package 3/14/17 for 9 tablets. There were 2 tablets missing from package which would have corresponded to the doses given on 3/15/17 at 6 a.m. and 2 p.m. LPN-B explained that Resident #8 gets the pain medication every 8 hours and she gave the 2 p.m. dose today. When asked about the process to obtain the medication if it was not available in the medication cart she stated "If (the) script is still good, (we) fill out pharmacy sheet and they would give us a code to get it out of the stat box." She stated "If no active script we need to wait for the doctor to call it into the pharmacy and then write a hard (paper) script." When asked if she was unable to get a response from the doctor, LPN-B stated they could call the medical director (Employee-Q) or the covering physician. When asked to see the stat box process, LPN-B brought surveyor into the medication room and locked in a cabinet was a "pharmacy control box" with a code lock present. LPN-B explained the pharmacy needed to give the code to open the combination lock. LPN-B showed the surveyor the Clonazepam 0.5 mg blisterpack which had a processing date of 3/14/17 for 60 tablets. There was one tablet missing from the pack. LPN-B stated she gave the first dose from the packet this morning. When asked about reordering the Clonazepam from the pharmacy, LPN-B stated "The last day I was here I ordered the Clonazepam (3/9/17). There was no documentation that the pharmacy was notified or that the pharmacy requested additional information.

Review of the stat box medication list included but was not limited to:

Oxycodone/APAP (Percocet) 5MG/325MG TAB

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ORAL with a quantity of 5,
Oxycodone/APAP 7.5/325 MG TAB ORAL with a quantity of 2, and
Oxycodone 5MG TAB ORAL with a quantity of 5.

Clonazepam was not listed as an available medication in the stat box.

On 3/15/17 at 3:05 p.m. an interview was conducted with the nurse on duty 3/14/17 at 10 p.m: (LPN-A). When asked why he didn't obtain the Percocet from the stat box at the time it was due, LPN-A stated "I called the pharmacy and they stated it was already sent out (the new blisterpack)." And "It was on the 5 o'clock run." LPN-A stated he "Told the 11p-7a nurse to give it once it arrived and that he gave her (Resident #8) Tylenol."

On 3/15/17 at 4:55 p.m., the Director of Nursing (Employee-B) and the Administrator were informed of the Percocet and Clonazepam not administered due to the medication not being available.

On 3/16/17 at 9:10 a.m. an interview was conducted with the Director of Nursing (Employee-B). When asked what her expectations were if medications were unavailable, Employee-B stated she would "Expect the nurses to get a new script if needed (from the doctor) if it was running out." She stated she would "Expect the nurses to document contacting the MD (doctor) and pharmacy, get the meds out of stat box if able or get another med ordered." Employee-B stated she spoke with the nurses that were identified and they have been educated on the process.

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F 441 SS=E	Continued From page 98 483.80(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 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:	F 441 F 441	1. Biohazard door has a new lock on it that is secured to prevent anyone from opening it without a key. All Biohazard waste, recepticals and sharp articles are put up properly in biohazard containers and removed per protocol. 2. All biohazard doors in the facility have the potential to be affected. 3. All housekeeping staff and licensed nursing staff will be in-serviced on making sure the biohazard doors are securely locked when closing the door and hazards associated with blood borne pathogens in biohazard closets. 4. The DCS/designee will monitor biohazard doors and biohazard waste disposal audits on the doors being securely locked and biohazard waste disposed properly 4xs a week for 30 days, then 2xs a week for 30 days. The results of the audits will be presented to QAPI committee for review and recommendations. 5. 04/18/17	04/18/2017

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	495235	A. BUILDING _____ B. WING _____	C 03/16/2017

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(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, 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 facility staff failed to ensure an effective infection control program related to biohazardous waste and blood borne pathogens.

The biohazard closet was open and available to Residents who were wandering unsupervised in the hallway. The closet contained, scattered on the floor, and sitting on top of red biohazardous

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waste recepticals, multiple forms of biohazardous waste, and used sharp articles that would be an infection control and injury hazard to the resident population.

The findings included:

On 3-14-17 during initial tour of the facility at 2:15 p.m., with the Director of Nursing (DON), the biohazard closet was found to be open and unlocked. Nursing staff members were at the end of the hallway and around a corner in the nursing station, not in view of the biohazard closet, nor able to observe the residents on that hallway. Multiple residents were wandering in the hallway unsupervised entering different rooms, to include Resident #6, who was found to be confused, agitated, ambulatory, and was walking aimlessly into rooms, opening doors, and leaving her rolling walker in the hallway, as she forgot to use it at times. Resident #6 was entered into the survey sample. Upon opening the door fully to expose it's contents, the following was found scattered on the floor and sitting on red biohazardous waste bins:

Blood borne pathogen contaminated used needles, (4) overflowing used sharps containers, filled with used needles, blood filled IV tubing, medications, etc. Also in the room scattered on the floor and in the open waste bins were used and visibly soiled gloves, used glass insulin medication vials, (3) soiled red infection control isolation waste and linen cans (2 metal, and 1 plastic), Intravenous blood drawing tubing and vacutainers with needles affixed to them, and filled with blood, used fingerstick blood sugar testing lancets, used shaving razors, broken glass, and (1) large red bin trash can with (5)

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vials of used injectable insulin which still contained some medication in them, and a visibly soiled wet hand towel. None of the waste containers had red bag liners in them for closed containment of the biohardous materials. The closet had a strong, foul human waste odor, which could be detected in the hallway outside of the room.

The DON immediately called for staff to help, and stated that this room should always be locked. The lock on the door was a numbered punch button electronic lock, and it was inoperable, and could not be locked. A maintenance department employee came to the room and removed 3 of the 4 sharps containers, and stated that he would box them and remove them to the outside of the building in a storage area to be picked up for incineration, and the DON went with him. The fourth sharps container was left in the room, with the other items. The room door was closed, however, could not be locked, and the surveyor stood there alone to observe the room. Resident #6 remained as did other residents in the hallway wandering. At 2:45 p.m. the Maintenance director came to the room and inspected the inoperable door lock, and stated this is broken, and I will have to replace it, no one told me it was broken. When asked how long the door lock had been inoperable, staff stated they did not know. At 2:45 p.m. a second and a third surveyor joined the observation. The maintenance director left the area to obtain a new door handle and lock. At 3:00 p.m. the maintenance director returned and fixed the lock, and locked the door.

The next morning on 3-15-17 at 9:00 a.m., the door to the biohazard closet was checked and found to be open/unlocked again. All of the items

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found the previous day were found still in the closet, except for the 3 sharps containers which were removed on the first observation, however, the fourth sharps container which was full to overflowing still remained in the closet also. The Corporate Registered Nurse (RN) Consultant observed the surveyor check the door, and immediately came to the room, and checked the door which had been unlocked from the inside by staff, and was left open, and unlocked. Resident #6 and other residents were again in the hallway wandering. The maintenance director was again called to the area, and changed the lock again, to one that could not be left unlocked, and could only be accessed with a key.

The Corporate RN Employee G, stated that the staff would be counseled and educated immediately on the hazards associated with blood borne pathogens in the biohazard closet, and to emphasize the importance of it always remaining locked.

Review of the facility infection control program policies revealed that The Centers for Disease Control (CDC) standards would be followed. CDC standards require that all contaminated biohazardous waste, and blood borne pathogens must be contained in an inaccessible area to prevent the spread of infection.

The facility Administration was made aware of the issue on 3-15-17, and 3-16-17 at the end of day debriefings, and no further information was available to be provided by the facility.