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F 000	INITIAL COMMENTS	F 000	This facility wishes this plan of correction to serve as the allegation of compliance.	

An unannounced Medicare/Medicaid standard survey was conducted 4/12/16 through 4/14/16. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey.

The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #1 through #19) and 4 closed record reviews (Residents #20 through #23).

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

F 279 F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

1. The corrective action for deficient practice was, Physician adjusted insulin dosage for Patient # 7 and a Care Plan for diabetic management initiated.
2. The facility identifies those residents with sliding scale insulin to be at risk for the deficient practice.
3. Measures put into place to prevent re-occurrence.
   a. In-service Licensed nurses on the appropriate and timely administration and insulin.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	4/29/2016

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

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This REQUIREMENT is not met as evidenced by:
Based on observation, facility record review, and clinical record review, the facility staff failed to develop a comprehensive care plan for 1 resident (Resident #7) of 23 residents in the survey sample.

Resident #7's care plan was not developed for diabetic management.

The findings include:

Resident #7, was initially admitted to the facility on 2-24-16. Diagnoses included diabetes, hypertension, anemia, peripheral vascular disease, atrial fibrillation, amputation of the left leg, cancer, and lung disease.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3-22-16 was coded as a 30 day admission assessment. Resident #7 was coded as having no memory deficits and was able to make own daily life decisions. The Resident was coded as needing limited to extensive assistance of one to two staff members to perform activities of daily living with the exception of eating. For eating, Resident #7 was coded as needing set up assistance only. The Resident was continent of bowel and bladder.

Resident #7 was observed 4-13-16 at 9:50 a.m. The Resident was sitting in a wheel chair fully dressed, alert and oriented. A Resident interview was then conducted. The Resident stated that his insulin was supposed to be given before he

b. Audit Mars for insulin administration and diabetic management care plan present 20% audit daily, 5 times a week for 3weeks , weekly times 4 weeks ,monthly times 2 months ,

4. Facility will monitor in QA&A quarterly committee.
5. The date of completion will be May 20, 2016. 5/20/2016

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ate, however, he stated that sometime he would finish his breakfast or lunch or dinner before he got the insulin.

Resident #7's clinical record was reviewed. Included was a most recent recapitulation of physician's orders dated 4-13-16, revealing what insulin the Resident was currently receiving. The two insulin physician's orders read;

1. Sliding scale insulin (SSI), "Insulin Lispro (Human) solution 100 unit/ml (milliliter) inject as per sliding scale if: 180-199 (milligrams/deciliter, mg/dl) = 1 unit, 200-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350 -400 = 9, > (greater than) 400 call MD. If < (less than) 60 call MD." Subcutaneously before meals and at bedtime related to type 2 Diabetes Mellitus without complications. At bedtime only given if blood glucose is >200 base on above scale." Ordered 4-9-2016.

Sliding scale insulin is a dose of insulin that is determined by the results of an Accucheck or finger stick blood sugar (FSBS). The FSBS was being tested at 7:30 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.

2. Insulin NPH (long acting) (human) (Isophane) Suspension 100 unit/ml inject 18 units subcutaneously every morning and at bedtime related to type 2 Diabetes Mellitus without complications. Ordered 4-9-2016.

Review of the Medication Administration Record (MAR) for April 2016 revealed that the SSI was administered late 6 times in 12 days. Those results follow;

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4-9-16 Ordered at 4:00 p.m., given at 5:56 p.m. (2 hours late & after a meal).
4-10-16 Ordered at 4:00 p.m., given at 6:24 p.m. (2 and 1/2 hours late & after a meal).
4-11-16 Ordered at 11:00 a.m., given at 12:07 p.m. (2 hours late & during a meal).
Ordered at 4:00 p.m., given at 7:54 p.m. (4 hours late, after a meal, & 1 hour before the next dose).
4-12-16 Ordered at 4:00 p.m., given at 5:10 p.m. (late).
Ordered at 9:00 p.m., given at 10:03 p.m. (late).

The MAR review further revealed that the NPH (long acting) Insulin was administered late 4 times in 12 days. Those results follow;

4-9-16 Ordered at 5:00 p.m., given at 6:12 p.m. (1 hour late).
4-10-16 Ordered at 5:00 p.m., given at 6:25 p.m. (1 and 1/2 hours late).
4-11-16 Ordered at 5:00 p.m., given at 7:54 p.m. (3 hours late).
4-12-16 Ordered at 8:00 a.m., given at 9:51 a.m. (2 hours late).

Review of Resident #7's care plan revealed no diabetic or insulin management care plan had been instituted. The Resident was admitted on 2-24-16, equaling 47 days stay, as of the time of survey.

On 4-13-16 at the end of day debrief, no further information could be provided by the facility.

F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for two Residents (Residents' #9 and #4) in a survey sample of 23 Residents.

1. For Resident #9, the self use of fluid thickener for dysphagia (difficulty swallowing) was not care planned; and

2. For Resident #4, the facility staff failed to revise care plan goals and interventions related to weight loss.

This tag is cross referenced to 12 VAC 5-371-250 (F).

1. The corrective action for resident # 9 and # 4 was immediately corrected.
2. The facility identifies those residents who self-administer Thickener and those residents on comfort care to be at risk.
3. The measure put into place to prevent re-occurrence:
   a. In-service Licenses nurses about updating and adjusting resident Care Plans as their condition changes.
   b. 100% audit of Care Plan for the residents with Thickener at bed side and comfort care weekly.
4. Facility will monitor performance through quarterly QA&A committee.
5. The date of completion will be May 20, 2016.

5/20/2016

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The findings included:

1. For Resident #9, the self use of fluid thickener for dysphagia (difficulty swallowing) was not care planned.

Resident #9, a female, was readmitted to the facility 3/24/16. Her diagnoses included chronic obstructive pulmonary disease, muscle weakness, chronic kidney disease, congestive heart failure, hypertension, tremor, chronic pain, type II diabetes mellitus, major depressive disorder, restless leg syndrome, gastroesophageal reflux disease, and hypothyroidism.

Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/31/16 was coded as an admission, five day assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. Resident #9 was coded as requiring supervision to limited assistance of one staff member to perform her activities of daily living.

Resident #9 was observed on initial tour of the facility, 4/12/16 and interviewed on 4/13/16 at 8:12 a.m. At both observations, Resident #9 was sitting in an easy chair in her bedroom, with a sling to her left arm. Resident #9 was alert and oriented. A can of "fluid thickener" was observed sitting on her over bed table. Resident #9 stated she used the "thickener" at home and it helped her to swallow her fluids. She stated she had used the thickener for "awhile" at home and put in an amount that she thought was helpful.

Review of Resident #9's clinical record revealed a

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signed physician's order that included, "4/4/16 Alternate small sips of nectar thick liquids with small bites of food every shift."

http://www.in.gov/fssa/files/aspiration_prevention_1.pdf indicates:

"Nectar-like: Fluids thin enough to be sipped through a straw or from a cup but thick enough to fall
off a tipped spoon slowly (e.g., buttermilk, eggnog like)."

Documentation revealed Resident #9 had utilized "nectar thickened liquids" during her previous admission to the facility and while at home.

Review of her clinical record, including the care plan, revealed no guidance to the staff that Resident #9 utilized the thickener on her own. Review of the care plan included:

"The resident has nutritional problem or potential nutritional problem. Recent hospitalization/therapeutic diet/Nectar thickened liquids/higher." Included in the "Interventions:

*Administer medications as ordered
*Develop an activity program that includes exercise, mobility. Offer activities of choice to help divert attention from food.
*Explain and reinforce to the resident the importance of utilizing the diet ordered. Encourage the resident to comply. Explain the consequences of refusal, obesity/malnutrition risk factors.
*Labs as ordered
*Monitor/document/report PRN (as needed) any s/sx(signs/symptoms) of dysphagia: Pocketing,

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Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat. Appears concerned during meals.
*Provide, serve diet as ordered. Monitor intake and record q (every) meal.
*Weekly weights admission date 3/24/16."

The care plan had been developed on 3/30/16.

The care plan was reviewed and no indication that Resident #9 mixed and utilized the thickener was evident.

When interviewed, the speech therapist (Other J) stated 4/13/16 at 3:10 p.m., she had assessed Resident #9 during her previous admission (ending on 3/23/16) for the use of the thickener. Other J stated as Resident #9 had utilized the thickener appropriately, she (Other J) did not have to train Resident #9 nor educate the staff on her use of thickener. Other J also stated the nursing staff was responsible for updating her care plan."

Guidance for the creation of an individualized care plan was provided by "Mosby's Fundamentals of Nursing 7th Edition, Potter-Perry, p. 268:

In any health care setting a nurse is responsible for providing a written pan of care for all clients. The plan of care sometimes takes several forms...In hospitals and community-based settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to

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direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another."

The administrator, DON (director of nursing) and corporate consultant were informed of the failure of the staff to update the care plan for the use of Resident #9's self administration of thickener, 4/13/16 at 4:45 p.m.

2. For Resident #4, the facility staff failed to revise care plan goals and interventions related to weight loss.

Resident #2 was originally admitted to the facility on 1/15/13 and readmitted on 2/23/16 with the diagnoses of, but not limited to, cerebrovascular accident (CVA-stroke), coronary artery disease, congestive heart failure (CHF) and diabetes mellitus.

The most recent Minimum Data Set (MDS) was a significant change MDS with an Assessment

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Reference Date (ARD) of 3/1/16. The MDS coded Resident #4 with severe cognitive impairment; required extensive assistance from staff for bed mobility, transfers, dressing, toileting and hygiene; and required set up assistance from staff for eating.

On 4/13/16 at 9:30 a.m., Resident #4 was observed in his room in a wheelchair. He was alert and answered questions in a soft voice.

Resident #4's clinical record was reviewed on 4/13/16. The review revealed a "Comfort Care Order Sheet" signed by the physician on 2/15/16. The comfort care orders included:

"...Discontinue all weights..." and,
"...I certify that this resident has 6 months or less to live due to end-stage disease/poor prognosis. Resident's condition has been discussed with POA/RP (power of attorney/responsible party) and the POA/RP has agreed to place the resident on comfort care."

Resident #4's care plan created on 9/11/15 and revised on 3/7/16 included:

"Focus
*The resident has unplanned/unexpected weight loss r/t (related to) Poor food intake, Recent hospitalization, Acute illness, swallowing difficulty...

Goal
*Resident will avoid significant weight loss through next review.

Interventions
*Dietitian consult as needed...

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*Monitor and evaluate any weight loss...
*Monitor and record food intake at each meal...
*Weigh as ordered..."

On 4/13/16 at approximately 4:35 p.m. the Administrator and Director of Nursing were asked why the care plan was not updated to remove weights/monitoring when Resident #4 became comfort care.

On 4/14/16 at 8:55 a.m. an interview was conducted with the Corporate Registered Nurse (Admin-D) regarding the careplan not being updated when the resident became comfort care. Admin-C stated "It is what it is."

No further information was provided by the facility staff.

F 280

F 281 SS=E 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for medication administration for two Residents (Residents' #9 and #6) in a survey sample of 23 Residents.

1. For Resident #9, the facility staff failed to ensure Pantoprazole and Levothyroxine were administered as ordered by the physician; and

F 281 F 281 SS=E 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

This tag is cross-referenced to VAC 5-371-200 (B).

1. There was no corrective action for those residents affected as the omissions were past for # 6, # 9 and # 1.
2. All residents are at risk for the omission of medications.
3. Measures taken to prevent re-occurrence:
   a. In-service Licensed nurses on the appropriate documentation and medication administration.

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F 281	Continued From page 11 2. For Resident #6, the facility staff failed to document medications as given. The findings included: 1. For Resident #9, the facility staff failed to ensure Pantoprazole and Levothyroxine were administered as ordered by the physician. Resident #9, a female, was readmitted to the facility 3/24/16. Her diagnoses included chronic obstructive pulmonary disease, muscle weakness, chronic kidney disease, congestive heart failure, hypertension, tremor, chronic pain, type II diabetes mellitus, major depressive disorder, restless leg syndrome, gastroesophageal reflux disease, and hypothyroidism. Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/31/16 was coded as an admission, five day assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. Resident #9 was coded as requiring supervision to limited assistance of one staff member to perform her activities of daily living. Review of Resident #9's clinical record revealed no evidence the following medications were administered: Levothyroxine 175 mcg (microgram) for hypothyroidism: 4/12/16 at 6 a.m. Pantoprazole Delayed Release 40 mg (milligram) for gastroesophageal reflux disease: 4/12/16 at 6 a.m.	F 281	b. MAR will be audited for accurate documentation of medications administered 20% daily 5 times a week for 3 weeks, weekly times 4 weeks , monthly times 2 months . 4. Facility will monitor performance through quarterly QA&A committee. 5. The date of completion will be May 20, 2016.	5/20/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Valid physician's orders were evident for the medications in question. No documentation was evident that Resident #9 refused the medications nor that she was not at the facility.

When interviewed, the DON (director of nursing) stated 4/13/16 at 4:45 p.m., "The expectation was for the nursing staff to document the administration of medications at the time of administration." She further stated she was unable to determine if the medications had not been given or if the nurse had not documented. The DON stated, "If not documented, not done..."

Review of the facility's policy entitled, "General Dose Preparation and Medication Administration"

"1. Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications.

6.1 Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight (sp)) on appropriate forms."

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

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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 consultant were informed of the failure of the staff to ensure Pantoprazole and Levothyroxine were administered per physician's orders for Resident #9, 4/13/16 at 4:45 p.m.

2. For Resident #6, the facility staff failed to document medications as given.

Resident #1 was admitted to the facility on 2/17/16. Diagnoses included fractures of the right and left leg, ribs and radius from a motor vehicle accident, diabetes and an acute subdural hematoma. The most recent MDS (minimum data set) dated 2/24/16 coded the resident's BIMS (brief interview of mental status) score as "3" out of a possible 15, or severe cognitive impairment. The MDS coded the resident as requiring limited to extensive assistance of one to two staff members for ADL's (activities of daily living) such as bed mobility and transferring.

Review of the MAR (medication administration record) for March, 2016, revealed the following omissions in documentation: Atenolol (blood pressure medication) 25 mg (milligrams) one daily not signed as given for 3/1/16, 3/2/16,

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3/4/16. Lantus (diabetic medication) 26 units at bedtime not documented on 3/1/16, 3/2/16, 3/3/16, 3/17/16 and 3/18/16. Pravastatin (high cholesterol) 40 mg at bedtime was not documented for 3/1/16, 3/3/16, 3/5/16, 3/17/16 and 3/18/16. Metformin (diabetic medication) 500 mg four times daily not documented as given for 3/1/16 (5:00 PM and 9:00 PM), 3/3/16 (9:00 PM), 3/4/16 (5:00 PM and 9:00 PM), 3/17/16 (9:00 PM), 3/18/16 (9:00 PM) and 3/26/16 (1:00 PM).

Review of the facility's policy and procedure titled, General Dose Preparation and Medication Administration read as followed: "Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, prn (as needed), application site) on appropriate forms." The DON (director of nursing) stated the facility used Mosby's as their professional standards.

Guidance is given to nursing by "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors. The recording of a medication includes the name of the medication, dose, route, and exact time of administration."

On 4/14/16 at 12:20 PM, the DON stated, The expectation is that the nurse "should document the medication when she gives it."

On 4/14/16 at 12:20 PM, the Administrator and DON were notified of above findings.

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F 309 SS=E	Continued From page 15 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309 F 309	483.25 PROVIDE CARE / SERVICES FOR HIGHEST WELL BEING	

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
3. For Resident #5, the facility failed to obtain physician ordered Accuchecks.

The findings included:

Resident #5 was admitted to the facility on 3/26/16. Diagnoses included sepsis, diabetes, high blood pressure and stroke. The most recent MDS (minimum data set) dated 4/1/16 coded the resident's BIMS (brief interview of mental status) score as "4" out of a possible 15, or severe cognitive impairment. The MDS coded the resident as requiring limited to extensive assistance of one to two staff members for ADL's (activities of daily living) such as bed mobility and transferring.

Review of the active physician's orders dated 3/26/16 contained the following order: Accuchecks (fingerstick blood samples to check glucose levels) before meals and at bedtime. The order was signed by the physician on 4/1/16. Review of the March and April MAR (medication administration record) revealed the order had been discontinued. There was no discontinue

This tag is cross referenced to VAC 5-371-220 (B)

1. No corrective action could be made as the deficient practice was past for resident # 5, # 7, # 17 and # 9.
2. All residents are at risk for the deficient practice.
3. Measures taken to prevent re-occurrence:
   a. In-service Licensed nurses on appropriate and timely documentation of medication administration.
   b. MAR will be audited for accurate administration of medications 20% daily 5 times a week for 3 weeks , weekly times 4 weeks , monthly times 2 months.
4. Facility will monitor performance through quarterly QA&A committee.
5. The date of completion will be May 20, 2016. 5/20/2016

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order on the record.

On 4/13/16 at 10:55 AM, the ADON (assistant director of nursing) stated, "We never did the Accuchecks; they were not indicated on the discharge orders." She went on to state that the nurse"hit the batch orders" (orders batched together, as in admission orders). "The physician did sign them."

On 4/13/16 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.

Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to provide physician ordered diabetic management for three residents, (Residents #7, 17, and #5) in a survey sample of 23 residents and the facility failed to follow doctor's orders for one Resident (Residents #9) in a survey sample of 23 Residents.

1. For Resident #9, the facility staff failed to ensure Pantoprazole and Levothyroxine were administered as ordered by the physician; and

1. Resident #7's insulin was administered late 10 times from 4-1-16 through 4-12-16.

2. Resident #17's insulin was not administered per physician's order on 4-9-16, and Finger stick Blood Sugar (FSBS) accuchecks were not completed on 4-2-16, and 4-9-16, and the FSBS results were not documented multiple times.

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3. For Resident #5, the facility failed to obtain physician ordered Accuchecks.

4. For Resident #9, the facility staff failed to ensure Pantoprazole and Levothyroxine were administered as ordered by the physician.

The findings included:

1. Resident #7, was initially admitted to the facility on 2-24-16. Diagnoses included diabetes, hypertension, anemia, peripheral vascular disease, atrial fibrillation, amputation of the left leg, cancer, and lung disease.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3-22-16 was coded as a 30 day admission assessment. Resident #7 was coded as having no memory deficits and was able to make own daily life decisions. The Resident was coded as needing limited to extensive assistance of one to two staff members to perform activities of daily living with the exception of eating. For eating, Resident #7 was coded as needing set up assistance only. The Resident was continent of bowel and bladder.

Resident #7 was observed 4-13-16 at 9:50 a.m. The Resident was sitting in a wheel chair fully dressed, alert and oriented. A Resident interview was then conducted. The Resident stated that his insulin was supposed to be given before he ate, however, he stated that sometime he would finish his breakfast or lunch or dinner before he got the insulin.

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Resident #7's clinical record was reviewed. Included was a most recent recapitulation of physician's orders dated 4-13-16, revealing what insulin the Resident was currently receiving. The two insulin physician's orders read;

1. Sliding scale insulin (SSI), "Insulin Lispro (Human) solution 100 unit/ml (milliliter) inject as per sliding scale if: 180-199 = 1 unit, 200-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350 -400 = 9, >400 call MD. If <60 call MD." Subcutaneously before meals and at bedtime related to type 2 Diabetes Mellitus without complications. At bedtime only given if blood glucose is >200 base on above scale." Ordered 4-9-2016.

Sliding scale insulin is a dose of insulin that is determined by the results of an Accucheck or finger stick blood sugar (FSBS). The FSBS was being tested at 7:30 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.

2. Insulin NPH (long acting) (human) (Isophane) Suspension 100 unit/ml inject 18 units subcutaneously every morning and at bedtime related to type 2 Diabetes Mellitus without complications. Ordered 4-9-2016.

Review of the Medication Administration Record (MAR) for April 2016 revealed that the SSI was administered late 6 times in 12 days. Those results follow;

4-9-16 Ordered at 4:00 p.m., given at 5:56 p.m. (2 hours late & after a meal).
4-10-16 Ordered at 4:00 p.m., given at 6:24 p.m. (2 and 1/2 hours late & after a meal).

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4-11-16 Ordered at 11:00 a.m., given at 12:07 p.m. (2 hours late & during a meal).
Ordered at 4:00 p.m., given at 7:54 p.m. (4 hours late, after a meal, & 1 hour before the next dose).
4-12-16 Ordered at 4:00 p.m., given at 5:10 p.m. (late).
Ordered at 9:00 p.m., given at 10:03 p.m. (late).

The MAR review further revealed that the NPH (long acting) Insulin was administered late 4 times in 12 days. Those results follow;

4-9-16 Ordered at 5:00 p.m., given at 6:12 p.m. (1 hour late).
4-10-16 Ordered at 5:00 p.m., given at 6:25 p.m. (1 and 1/2 hours late).
4-11-16 Ordered at 5:00 p.m., given at 7:54 p.m. (3 hours late).
4-12-16 Ordered at 8:00 a.m., given at 9:51 a.m. (2 hours late).

Review of Resident #7's care plan revealed no diabetic or insulin management care plan had been instituted.

Review of the facility policy on Medication administration revealed;
"The facility staff should administer the correct medication to the correct Resident, at the correct time as set forth in the facility Medication Administration Times Schedule."

On 4-12-16 at the end of day debrief the issue with the wrong amount of sliding scale insulin was reviewed with The Director of Nursing (DON). She agreed that the insulin was administered late. No further information was provided by the

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facility.

2. Resident #17, was initially admitted to the facility on 3-30-16. Diagnoses included Sepsis, End stage renal disease with dialysis, diabetes, hypertension, atrial fibrillation, lung disease, and high cholesterol.

Resident #17's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-6-16 was coded as a 5 day admission assessment. Resident #17 was coded as having no memory deficits and was able to make own daily life decisions. The Resident was coded as needing limited assistance of one staff member to perform activities of daily living with the exception of eating, and bathing. For eating, and bathing, Resident #7 was coded as needing set up assistance only. The Resident was continent of bowel and bladder.

Resident #17 was observed 4-13-16 at 3:30 p.m. The Resident was sitting in a wheel chair fully dressed, alert and oriented. A Resident interview was then conducted.

Resident #7's clinical record was reviewed. Included was a most recent recapitulation of physician's orders dated 4-14-16, revealing what insulin the Resident was currently receiving. The two insulin physician's orders read;

1. "Insulin Glargine Solution 100 unit/ml (milliliters) inject 20 units subcutaneously at bedtime related to type 2 Diabetes Mellitus with hyperglycemia." Ordered 3-31-2016.

2. "Accuchecks AC (before meals) & HS (at

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bedtime) for DM (Diabetes Mellitus).

The Finger stick Blood Sugar (FSBS) accucheck testing was being completed at 6:30 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.

Review of the Medication Administration Record (MAR) for April 2016 revealed that the Insulin was not administered on 4-9-16 at 9:00 p.m., and the FSBS accucheck was not completed on 4-2-16 at 6:30 a.m., on 4-9-16 at 9:00 p.m., and on 4-10-16 at 4:00 p.m..

Review of the Nursing progress notes revealed that no note had been written on 4-9-16, and on 4-2-16, and 4-10-16, no information was documented as to the reason the accuchecks were not documented or obtained.

An interview was conducted with LPN unit manager who stated "if it isn't documented it isn't done."

Review of Resident #17's care plan revealed administer medications as ordered.

Review of the facility policy on Medication administration revealed;
"The facility staff should administer the correct medication to the correct Resident, at the correct time as set forth in the facility Medication Administration Times Schedule."

On 4-13-16 at the end of day debrief the issues with the FSBS and insulin was reviewed with The Director of Nursing (DON). No further information was provided by the facility.

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4. For Resident #9, the facility staff failed to ensure Pantoprazole and Levothyroxine were administered as ordered by the physician.

Resident #9, a female, was readmitted to the facility 3/24/16. Her diagnoses included chronic obstructive pulmonary disease, muscle weakness, chronic kidney disease, congestive heart failure, hypertension, tremor, chronic pain, type II diabetes mellitus, major depressive disorder, restless leg syndrome, gastroesophageal reflux disease, and hypothyroidism.

Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/31/16 was coded as an admission, five day assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. Resident #9 was coded as requiring supervision to limited assistance of one staff member to perform her activities of daily living.

Review of Resident #9's clinical record revealed no evidence the following medications were administered:

Levothyroxine 175 mcg (microgram) for hypothyroidism: 4/12/16 at 6 a.m.

Pantoprazole Delayed Release 40 mg (milligram) for gastroesophageal reflux disease: 4/12/16 at 6 a.m.

Valid physician's orders were evident for the medications in question. No documentation was

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evident that Resident #9 refused the medications nor that she was not at the facility.

When interviewed, the DON (director of nursing) stated 4/13/16 at 4:45 p.m., "The expectation was for the nursing staff to document the administration of medications at the time of administration." She further stated she was unable to determine if the medications had not been given or if the nurse had not documented. The DON stated, "If not documented, not done..."

Review of the facility's policy entitled, "General Dose Preparation and Medication Administration"

"1. Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications.

6.1 Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight (sp)) on appropriate forms."

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:

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F 309	Continued From page 24 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 consultant were informed of the failure of the staff to ensure Pantoprazole and Levothyroxine were administered per physician's orders for Resident #9, 4/13/16 at 4:45 p.m.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to perform services to prevent and promote the healing of pressure ulcers in two Residents (Residents' #2, and #20) in the survey sample of 23 Residents, resulting in harm for Resident #2. 1. For Resident #2, the facility staff failed to	F 314	F 314 SS=G 483.25(c) TREATMENT / SVCS TO PREVENT / HEAL PRESSURE SORES 1. Corrective action for resident # 2, a treatment was obtained and appropriate documentation was implemented and Care Plan adjusted. Resident # 20, no further action, patient was discharged from the facility. 2. All residents are at risk for deficient practice. 3. Measures taken to prevent re-occurrence: a. In-service Licensed nurses on prevention, monitoring, treatment and documentation of pressure ulcers. In-service on development of plan of care to prevent pressure ulcers.	

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provide preventive care and assessment. Failed to monitor for the development of ulcers, and failed to implement a comprehensive care plan to prevent 2 avoidable pressure ulcers from forming on 3-24-16. The staff then failed to treat the first 2 ulcers, and, failed to assess, and implement a care plan for, and prevent three further ulcers from forming and being identified on 4-12-16, and 4-13-16, 19 days after the initial 2 ulcers were identified. The facility staff further failed to promote healing for all 5 pressure ulcers which included two stage 2 ulcers, one unstageable ulcer, one deep tissue injury, and a new stage 3 ulcer found by surveyors, resulting in harm.

2. For Resident #20, the facility staff failed to adequately assess, document and monitor skin breakdown.

The findings included:

1. Resident #2 was admitted to the facility on 3-11-16. Diagnoses included; depression, Diabetes, ischemic heart disease, pulmonary embolism, atrial fibrillation, congestive heart failure, respiratory failure with tracheostomy and continuous oxygen via trach mask, benign prostatic hypertrophy with chronic Foley catheter, anemia, gastostomy tube and feeding, anoxic brain injury, and hypertension.

Resident #2's Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3-18-16 coded the Resident with no cognitive impairment. Resident #2 required extensive physical assistance from one to two staff members, with activities of daily living, and was coded as not having any pressure ulcers on admission. The Resident had a long

b. Audit all skin-assessments and Care Plan on admissions with appropriate wound documentation as needed.
c. 10% audit of skin assessments daily 5 times a week for 3 weeks, weekly for 4 weeks , monthly times 2 months .

4. Facility will monitor performance through quarterly QA&A committee.
5. The date of completion will be May 20, 2016. 5/20/2016

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standing Foley catheter (urine drainage) due to an obstruction, and was incontinent of bowel.

At area M-0100 through M-1200 under the MDS skin conditions section of the assessment, the Resident was coded to be at risk for pressure ulcers, had no pressure ulcers, and had no other skin problems such as rashes, and or moisture associated skin damage. The only preventive measures coded were a pressure reduction mattress for the bed, which all residents were given upon admission according to the Director of nursing (DON), and was the standard mattress used for all residents.

A 14 day MDS assessment with an ARD date of 3-24-16 was completed, and at area M-0100 through M-1200 under the MDS skin conditions section of the assessment, the Resident was coded to be at risk for pressure ulcers. The Resident had two stage 2 pressure ulcers, that were not present on admission, and were identified on 3-24-16. The Resident had no other skin problems such as rashes, and or moisture associated skin damage. The only preventive measures coded were a pressure reduction mattress for the bed, which all residents were given upon admission according to the Director of nursing (DON), and was the standard mattress used for all residents. No new orders for treatment, nor new interventions were instituted after the 2 stage two pressure ulcers were identified, and through the time of survey.

On 4-12-16 at 2:30 p.m. the first observation of Resident #2 was conducted during initial tour of the facility with Licensed Practical Nurse (LPN) E, he was found laying in bed partially on his right side with oxygen infusing at 5 liters per minute

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though a tracheostomy mask, and a Foley catheter was noted to be draining dark yellow urine with white sediment in it. The Resident was able to speak and make his needs known, and stated he was thirsty and wanted water. A second observation of Resident #2 was conducted at 4:30 p.m., and the Resident was sleeping in bed on an Atmos 4000 static air mattress with the controls reading half way between minimum and maximum fill normal pressure.

On 4-13-16 Resident #2's Admission full Nursing Assessment was reviewed and it was dated as complete on 3-17-16. The "Skin" section of the assessment revealed no pressure ulcers or skin integrity problems on the buttocks, sacrum or penis. Nothing was documented under "skin treatment ordered or required."

Review of the "Weekly Skin Assessment, and Wound Record" sheets were documented as follows:

Documented on 3-21-16 no pressure ulcers, and "groin red".
Documented on 3-24-15 area (1) Coccyx pressure measuring 1.3 x 1 centimeters (cm) stage 2. Area (2) Coccyx pressure measuring 2.2 x 1.4 cm stage 2.

Both wounds were documented on the weekly skin sheet as "Worsening, beefy red, and Calmoseptine" as the treatment, however, no physicians order appeared for this incontinence barrier cream, and it did not appear on the Treatment Administration Record (TAR) through the time of survey. As no order appeared in the clinical record or on the TAR, nursing staff were

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not documenting that it had ever been instituted or administered.

Documented on 4-12-16;
Area (1) Right Buttock (Coccyx) pressure measuring 3 x 2.3 cm stage 2.
Area (2) Left Buttock (Coccyx) pressure no measurement and stage 2.
Area (3) Left Trochanter (hip) pressure measuring 5 x 4 cm suspected deep tissue injury.
Area (4) Sacrum pressure 9 x 8 cm stage 2.
Area (5) Left Gluteal fold (Ishium) pressure 7 x 2 cm stage 2.

No treatment was described in any of the weekly skin or wound records for 4-12-16.

On 4-13-16 a third observation of Resident #2 was conducted at 10:00 a.m., and he was found lying in bed on his back with oxygen infusing at 5 liters per minute through a tracheostomy mask, and a Foley catheter was noted to be draining dark yellow urine with white sediment in it. The Resident was able to speak and make his needs known, and stated he was uncomfortable and wanted to be repositioned. The Resident was still lying on an Atmos 4000 static air mattress with the controls reading half way between minimum and maximum fill normal pressure.

On 4-13-16 a fourth observation was conducted of the Resident at 3:30 p.m., during wound measurement observations and incontinence care with LPN E. Resident #2 was found to have five pressure ulcers. The numbering of those 5 ulcers is in the following parentheses:

(#1) left and right inner buttocks' with diffuse

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open stage 2 pressure areas measuring 10 x 6 cm combined, the (#2) left trochanter (hip) with a deep tissue injury measuring 4.5 x 2.5 cm, the (#3) left ischial area under the left buttock with red angry margins and a black eschar center obscuring the wound base, measuring 9 x 1.5 cm which was an unstageable wound, and sacrum area 9 X 8 cm stage 2 and a fifth (#5) wound was found by the surveyor not previously documented on the Resident's penis. During incontinence care the surveyor wished to view the Foley catheter care, and the penile meatus was cleaned and found to have foul purulent drainage which was tan in color, and thick with mucous strings. Upon LPN E's removal of the drainage from the penile meatus (#5) a stage 3 pressure ulcer was found measuring 1 x 1 cm with a small amount of yellow slough in the base of the wound. The pressure ulcer was created by pressure of the Foley catheter, which had not been repositioned or stabilized with a device to the Resident's extremity to prevent rubbing and pressure in one location. The Resident had a bowel movement during care, and it was noted to be firm and formed. LPN E was asked if the Resident had loose bowel movements, and she replied "no" that the Resident normally had formed bowel movements as we had just experienced. The Resident wore an incontinent brief which was dry prior to the bowel movement, as the Foley catheter contained all urine. The Resident was still laying on an Atmos 4000 static air mattress with the controls reading half way between minimum and maximum fill normal pressure.

Guidance is provided for the staging of pressure ulcers as follows:
National Pressure Ulcer Advisory Panel (NPUAP)

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announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury FOR IMMEDIATE RELEASE April 13, 2016.
"Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury."
Nursing progress notes were reviewed from admission to the time of survey. No notes describe any pressure ulcer identification, treatments, assessments for pressure ulcers, or changes to the care plan for Resident #2. On 4-12-16, and 4-13-16, and during survey, nursing

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notes began to be documented that the Resident was non-compliant with turning and positioning, after 5 pressure ulcers had already formed, in the one month since admission. Nursing notes did describe Resident #2 and totally dependant on staff for positioning.

No physician orders were obtained to prevent or treat pressure ulcers for Resident #2. On 4-12-16 during survey, the facility staff obtained an order for a special pressure relieving alternating air pressure mattress, which was the Atmos 9000. The Specialty mattress was applied to Resident #2's bed on 4-14-16, just prior to survey exit. The Resident was receiving iron and a multivitamin for Anemia, which had been ordered on admission, and prior to the identification of the multiple pressure ulcers. The physician orders also revealed an "as needed" (PRN) standing facility order, given to all Residents upon admission, and read; "Wound Consult PRN". This had never been obtained for Resident #2.

On 4-13-16 Resident #2's care plan was reviewed and revealed no measurable objectives, and that on 3-22-16 a new "Focus" was instituted which read; Impaired skin integrity pressure areas on coccyx, with potential for further skin impairment due to weakness, incontinence, peripheral vascular disease, refusal to turn and diabetes. Expected skin breakdown due to non-compliance with positioning. Revised on 4-12-16. "Goal" Resident will have no evidence of skin impairment through next review, created on 3-22-16, and revised on 3-24-16. "Interventions" were "keep skin clean & dry, Lotion to dry skin, peri-care with incontinence episodes, weekly skin assessments, treatments as ordered (none were

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ordered), and on 4-12-16, during survey, pressure reduction mattress was added.

On 4-13-16 at the end of day meeting, facility staff were asked to show evidence of how Resident #2's wounds were unavoidable.

On 4-14-16 at 9:30 a.m. the Director of Nursing (DON) was not able to provide any evidence or documentation as to the 5 wounds at different stages of development being unavoidable, she did however want surveyors to speak with the physician of Resident #2 who was also the facility medical director. The physician talked with surveyors and stated that the cause of pressure ulcers is not relieving pressure, and it it much easier to prevent wounds than try to heal them after they have formed. He went on to say offloading the wounds is #1 as far as interventions. The physician was asked what had been done to prevent these wounds to Resident #2, and what had been done to heal them, and prevent new wounds. The doctor stated he would have to assess the whole problem & then plan interventions.

The Director of Nursing (DON) stated that Secura ointment had been used for Resident #2, from the time of admission, until 4-6-16, when Calmoseptine was begun. Manufacturer's guidance follows below for both ointments;

SECURA Protective Ointment Skin Protectant is described by the manufacturer as below:

"Contains, 98% Petrolatum, Clove oil helps mask odor, Vitamins A, D and E to soothe and condition sensitive skin. Indications for use, Skin protectant. Helps treat and prevent rash

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associated with diaper use or continued exposure to feces, urine or both. Protects skin from minor irritation associated with diaper dermatitis and exposure to feces and urine, and helps seal out wetness. Warnings; For external use only. Avoid contact with eyes. Not to be applied over deep or puncture wounds, infections or lacerations. If condition worsens or does not improve within 7 days, consult a doctor."

Calmoseptine ointment is described by the manufacturer as below:

Drug Facts
"Menthol
0.44%.....Ex
ternal analgesic / Anti-itch
urine diarrhea perspiration fistula drainage
feeding tube site leakage
minor burns cuts scrapes itching
Zinc Oxide
20.6%.....Skin
protectant / Anorectal astringent
Active ingredients: Purpose
A moisture barrier that prevents & helps heal skin irritations from:
wound drainage (peri-wound skin)
W a r n i n g s : For external use only Not for deep or puncture wounds. If condition worsens or does not improve within 7 days, consult a doctor.
D i r e c t i o n s : C leanse skin gently with mild skin cleanser. Pat dry or allow to air dry. Apply a thin layer of Calmoseptine Ointment to reddened or irritated skin 2-4 times daily, or after each incontinent episode or diaper change to promote comfort and long lasting protection. Inactive ingredients: calamine, chlorothymol, glycerin, lanolin, phenol."

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Neither of the ointments are recommended for pressure ulcer use by the manufacturer's guidelines, and neither ointment was ordered by a physician. The DON stated these ointments were used for all residents with incontinence. Review of all of the Treatment and Medication Administration Records (MAR/TAR) for Resident #2 revealed no documentation that these ointments were ever administered, and gave no guidance to nursing as to when or how to apply these ointments as they did not appear anywhere in the clinical record, and were not applied after incontinence care, during surveyor wound observation.

Review of the facility policy on "Pressure Ulcer Prevention and Management Program" revealed; "Avoidable pressure ulcers"..... happen if "the Center did not do one or more of the following."
1). Evaluate the patient's clinical condition and pressure ulcer risk.
2). Define and implement interventions that are consistent with patient needs, patient goals, and recognized standards of practice, monitor and evaluate the impact of the interventions.
3). Revise interventions as appropriate.

The facility staff documented that the Resident was at risk for pressure ulcer development on admission on 3-11-16, however, did not institute a care plan for 11 days after admission, and until 3-22-14, when the Resident was noted to have a red groin, and by 3-24-16, had (2) stage 2 pressure ulcers identified.

No interventions were added or revised to promote healing from 3-22-16 until the time of survey on 4-12-16, and the Resident had then (5)

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pressure areas, to include; Two at stage two, one that was unstageable, one that was a deep tissue injury, and one that was found by the surveyor during wound and incontinence care that was a stage 3.

At the time of survey on 4-12-16, the specialty mattress was ordered and was not applied until 4-14-16.

There was an addition to the care plan on 3-25-16 that stated "treatments as ordered", however, no treatments were ever ordered. Interventions were ineffective, not consistent with patient needs, not evaluated for impact nor revised, resulting in avoidable wounds. The Resident did not receive the necessary treatment and services to promote healing of the two initial pressure ulcers, and so did not prevent the three (multiple avoidable) added pressure ulcers from developing, resulting in harm for Resident #2.

The Administrator, DON, and the Registered Nurse (RN) Regional Consultant were made aware of the harm level deficiency at the end of day debrief on 4-13-16, and 4-14-16. No further information was supplied by the facility.

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2. For Resident #20, the facility staff failed to adequately assess, document and monitor skin breakdown. There was no weekly skin assessment documented between admission 2/15/16 and 2/25/16. And Left buttock-Pressure 3 x 3 x 0.1 (no stage or other descriptions were documented); Left buttock-Pressure 4 x 3 x 0.1 (no stage or other descriptions were documented);

Resident #20 was admitted to the facility on 2/15/16 and discharged home on 3/12/16. The diagnoses upon admission included, but not limited to, right healing femur fracture, urinary tract infection (UTI), overactive bladder, and diabetes mellitus. Being Resident #20 was no longer in the facility, a closed record review was conducted.

The most recent full Minimum Data Set (MDS) was an initial assessment with an Assessment Reference Date (ARD) of 2/22/16. The MDS coded Resident #20 with moderate cognitive impairment; required extensive assistance from 2 staff members for bed mobility, transfers and toilet use; required extensive assistance from one staff member for dressing, personal hygiene and bathing; and was frequently incontinent of bowel and bladder. Resident #20 was coded as being 65 inches in height and 190 pounds. The MDS coded Resident #20 with one Stage 2 pressure

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ulcer, present on admission; surgical wound (s); skin tear (s); skin and ulcer treatments: pressure reducing device for chair, pressure reducing device for bed, pressure ulcer care, surgical wound care and applications of ointments/medications other than to feet.

On 4/13/16 Resident #20's electronic and paper clinical record was reviewed. The review revealed a computerized "Admission Assessment/Screening-Nursing" form dated 2/15/16 at 16:54 (4:54 p.m.) which included the following skin issue documentation:
Units of measure in centimeters

Site: Right Trochanter (hip) Surgical Incision 6 x 0.2;
Right Trochanter (hip) Surgical Incision 9 x 0.2;
Left buttock-Pressure 3 x 3 x 0.1 (no stage or other descriptions were documented);
Left buttock-Pressure 4 x 3 x 0.1 (no stage or other descriptions were documented);
Sacrum-Skin Tear 15 x 0.2 x 0.1
left lower arm-Skin Tear 4 x 3 x 0.1

The "Wound Record (Revised)" form dated 2/16/16 included the following documentation of skin issues present on admission:

"Wound #1...left lower arm...skin tear... (measured in centimeters)...4 x 3 x 0.1 (length/width/depth)...Current treatment plan: non adhesive dressing."
"Wound #2...sacrum...skin tear...15 x 0.1 x 0.2...Current treatment plan: calmoseptine with every brief change."
"Wound #3...left buttock...pressure...Stage II...4 x 4 x 0.1...Current treatment plan: calmoseptine."
"Wound #4...right hip...surgical...9 x 0.1 x

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0...Current treatment plan: dry dressing and staples to stay on and intact until seen by dr. (name) in 10 days."
"Wound #5...right hip...surgical...6 x 0.1 x 0...Current treatment plan: dry dressing daily until seen by dr. (name) in 10 days."

Weekly skin assessments performed by nurses were reviewed and included the following documented skin observations:

There was no weekly skin assessment documented between admission 2/15/16 and 2/25/16.

2/25/16:
Site-Type-Length-Width-Depth-Stage
Right trochanter (hip) surgical incision (no measurements or incision description documented);
Left buttock-Pressure 2 x 3 (no stage was documented);
Left buttock-Pressure 2 x 3 (no stage was documented);
Sacrum-Skin Tear (no measurements documented);
Left lower arm-Skin Tear 5 x 5.

3/2/16:
Abdomen-Bruising
Groin-Rash
Right Buttock-Rash
Left Buttock-Pressure 2 x 3 N/A (not applicable)-no stage.

3/9/16:
Left Buttock-Pressure 2.5 x 3 (no stage was documented);
Notes: groin, sacrum, and in between thighs are

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red/rash.

Resident #20's care plan included the following: "Focus The resident has a pressure ulcer: Lt (left) buttock with potential for further pressure ulcer development r/t (related to) incontinence, oxygen use, decreased mobility...Interventions Administer treatments as ordered and monitor of effectiveness...Monitor nutritional status. Provide supplements as ordered, monitor intake and record...Position resident as needed."

"Focus The resident has a Skin Tears to Lt. lower arm and sacrum...Interventions Encourage good nutrition and hydration in order to promote healthier skin...The resident needs their nails kept short to reduce risk of scratching or injury from picking skin...Treatment as orders."

"Focus Potential for skin impairment...Interventions Keep skin clean and dry...Pressure reduction mattress...Weekly Skin Assessment."

Physician's orders for wound care included, but not limited to, the following:

2/16/16-"dry dressing daily to right hip every evening..."
2/21/16-"Desitin Maximum Strength Paste 40% (Zinc Oxide) Apply to left Buttock topically every shift for prophylaxis." Discontinued 2/28/16.
2/21/16-"Nystatin Cream 100000 UNIT/GM (units per gram) Apply to inner thighs topically every shift for redness." Continued until discharge.
2/28/16-"Cleanse left buttock w/NS (with normal saline), cover w/mepilex border QOD (every other day)..."(Mepilex is a self-adherent soft silicone foam dressing that absorbs exudate, maintains a

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moist wound environment and minimises (sic) the risk for maceration); Rewritten 3/1/16.
3/1/16-"Cleanse left buttock w/NS, cover w/mepilex border QOD..." Continued until discharge.
3/9/16-"9000 mattress for pressure relief."
Treatments per physician orders were documented as administered. Physician progress notes did not include skin impairment documentation.

Nurse Progress Notes included the following documentation:

"2/15/16...Assessment...left arm has scattered bruising with a skin tear to lower arm, left buttocks has 2 stage 2 pressure ulcers that are left OTA (open to air), right hip has 2 surgical incisions...Recommendations: continue to monitor"

"2/28/16 15:13 (3:13 p.m.)...Desitin maximum Strength Past 40% Apply to left Buttock topically every shift for prophylaxis Change in treatment."

"2/28/16 16:30 (4:30 p.m.)...Resident noted with open areas to left buttock which measure 6 x 2 x 0.2 w/spaces of epithelized tissue between. Treatment changed to mepilex QOD..."

"3/1/16 23:14 (11:14 p.m.)...Cleanse left buttock w/NS, cover w/ mepilex border QOD until every evening shift every 2 day (s) passed on to next shift."

"3/2/16 23:56 (11:56 p.m.)...Surgical incisions to the right hip are dry and shows no signs of drainage or infection, treatment was D/Ced (discontinued) and incision left open to air."

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Progress notes contained documentation that Resident #20 was incontinent of bowel and bladder.

On 4/14/16 at 8:40 a.m. an interview was conducted with the Corporate Registered Nurse (RN)-(Admin-D). Admin-D explained Resident #20 was admitted with a surgical wound to the right hip, a stage 2 pressure ulcer to left buttock and skin tears. The concern on if treatments were implemented upon admission was discussed. At 9:40 a.m. Admin-D stated Resident #20 "Was admitted with no dressings on areas and hospital ordered (to) leave open to air." Admin-D presented a "(Hospital Name) Clinical Handoff Checklist & Worksheet" with a "Collected On" date of 2/15/16 with a "Visit Start" date of 2/9/16. The worksheet included Resident #20's skin assessments, summarized as follows:

Left Buttock-Stage 1 no dressing-1 x 1 (not known if measurement was in centimeters or inches).
Right Buttock-Stage 2, no dressing.
Right Thigh incision-gauze and tape.
Coccyx-crack in between right and left buttocks-skin tear.
Left Arm-skin tear-Allevyn over top.

On 4/16/16 at 11:45 a.m. an interview was conducted with the Assistant Director of Nursing (Admin-C). Admin-C explained Resident #20, and most residents, have a "Protective standing ointment applied." Admin-C presented information about "SECURA Protective Ointment" which is described as "a semi-transparent protective ointment that protects and conditions the skin." Admin-C reviewed and discussed the

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treatments as ordered by the physician. Admin-C stated Resident #20 was discharged home on 3/12/16 with (Name of Company) home health to see the resident the following day. The discharge instructions included a list of the current medication and treatment records. When asked about the missing skin assessment for 2/22/16, Admin-C stated "I don't have it." When asked if it was missed, Admin-C stated "Yes."

On 4/14/16 at approximately 12:20 p.m., the Administrator, Director of Nursing and Corporate RN were informed of concerns that accurate assessments of pressure ulcer areas on buttocks were not completed (not staged or described adequately) and the missing assessment for 2/22/16. The wound care policy was requested.

On 4/14/16 at 1:10 p.m. Admin-C stated the facility "Does not have a formal wound care protocol." It was discussed and questioned how a nurse would know how to properly assess and treat wounds without a facility protocol.
A "PRESSURE ULCER PREVENTION AND MANAGEMENT PROGRAM" "Nursing Orientation Teaching/Learning Module" dated July 2014 was presented which included basic principles of managing skin and preventing ulcers. The program section "Skin Assessments" included:
"Perform weekly skin assessments; i.e., every 7 days." And,
"Care Plan specific interventions should be implemented based on skin assessment outcomes and individual patient needs."
Section "PRESSURE ULCER MANAGEMENT ONCE BREAKDOWN HAS OCCURRED:" included
"Assess, document, and notify the patient, family

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F 314	Continued From page 43 and medical provider, Implement specific, individualized interventions such as the use of a pressure relieving mattress, wound treatments, and/or other types of pressure relieving devices. Implement a care plan that reflects appropriate goals, outcomes, interventions, and evaluations to determine effectiveness of interventions... Complete pressure ulcer documentation weekly." No further information was provided by the facility staff regarding the facility's failure to adequately document assessments and monitoring of Resident #20's wounds.	F 314		
F 323 SS=D	Complaint Deficiency 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation review, and staff interview, the facility staff failed to maintain a safe environment for one of six medication carts within the facility. The north medication cart was left opened and unlocked, without staff nearby or in line of sight.	F 323	F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES This tag is cross referenced to 12 VAC 5-371-220 (A) 1. The corrective action: The Med Cart was locked. 2. All residents are at risk for the deficient practice. 3. Measures taken to prevent the re-occurrence: a. In-service Licensed nurses on appropriate locking of Med Carts when not in use. b. Audit of Med Carts twice a day, 5 times a week for 3 weeks, weekly times 4 weeks, monthly times 2 months .	

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F 323	Continued From page 44 The findings included: During observation of medication rooms and carts, the north medication cart was observed 4/14/16 at 11:15 a.m. Upon checking the cart, the medication cart was unlocked and the medication drawers were easily opened. No staff member was observed in the hall near or in line of sight of the medication cart. Residents and visitors were observed in the hall passing by and near the cart. Staff on the unit observed the cart being checked and paged LPN (licensed practical nurse) D. LPN D returned to the cart at 11:20 a.m. and stated the cart was "supposed to be locked." LPN D stated she was administering medications for the Residents covered by north medication cart. Review of the policy entitled "General Dose Preparation and Medication Administration" included: "7. Facility should ensure that medication carts are always locked when out of sight or unattended." The administrator, DON (director of nursing), and corporate consultant were informed of the failure of the staff to ensure the north medication cart was locked when left unattended or out of sight, 4/14/16 at end of day conference.	F 323	4. Facility will monitor performance through quarterly QA&A committee. 5. The date of completion will be May 20, 2016.	5/20/2016
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	F 371 SS=E 483.25(i) FOOD PROCURE, STORE/ PREPARE / SERVE - SANITARY	

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F 371	Continued From page 45 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to prepare food in a sanitary manner. The facility staff failed to ensure that 78 stored food trays were air dried, instead of wet nested. The Findings included: On 4/12/16 at 2:00 P.M. a tour was conducted of the kitchen. A tall stack of 78 stored food trays were wet nested. When the trays were separated, and held up at eye level for viewing, several drops of water spilled onto the floor. The trays had not been allowed to be air dried after being washed and prior to being stored. On 4/12/16 at 2:05 P.M., an interview was conducted with the Dietary Manager (Other F). When asked about the importance of air drying, she stated, "We'll have to re-run these. They shouldn't be like that. They've got to be air dried because of contamination." On 4/12/16 at 2:50 P.M. an interview was conducted with the Registered Dietician Technician (Other G). She was asked about the potential dangers of wet nesting. She stated, "Of	F 371	This tag is cross referenced to VAC 5-371-340 (A) 1. The corrective action taken: Immediately all trays were re-washed and dried during the Survey. 2. All residents are at risk for the deficient practice. 3. Measures taken to prevent the re-occurrence: a. Dietary Manager in-services dietary staff on appropriate method of all drying trays. b. Trays will be placed on air drying rack after washing. c. Observation of trays at meal times daily to monitor compliance for 3 weeks, weekly times 4 weeks, monthly times 2 months. 4. Facility will monitor performance through quarterly QA&A committee. 5. The date of completion will be May 20, 2016.	5/20/2016

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course we need to have them air dried so there's no wet-nesting or cross contamination and they're safe for our residents. There could be something on the tray from another resident, or food borne illness, anything of that nature. We don't have a specific policy."

On 4/13/16 the Administrator (Administration A) was informed of the findings. The surveyor was given a copy of an Inservice Education Record that was conducted on 4/12/16 at 3:30 P.M. the Record stated, "All trays are to air dry before placing trays on holder. How to air dry trays to prevent wet nesting. It was signed by 14 of 14 dietary staff.

F 425 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A 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.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

F 371

F 425 SS=D 483.60(a), (b) PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH

F 425

This tag is cross referenced to VAC 5-371-300 (A)

1. No corrective action as the deficient practice was past.
2. Those residents with an order for Clonazepam are at risk for the deficient practice.
3. Measures taken to prevent the re-occurrence:
   a. In-service Licensed nurses on proper process of obtaining a prescription from the Physician for Clonazepam.
   b. Audit residents with orders for Clonazepam daily, 5 days a week for 3 weeks, weekly times 4 weeks , monthly times 2 months

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F 425	Continued From page 47	F 425	4. Facility will monitor performance through quarterly QA&A committee. 5. The date of completion will be May 20, 2016.	5/20/2016

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 anti-anxiety medication was available for administration for one Resident (Resident #10) in the survey sample of 23 Residents.

For Resident #10, Clonazepam (an anti-anxiety medication) was not available for administration for three days after it had been ordered.

The findings included:

Resident #10, a female, was admitted to the facility 4/8/16. Her diagnoses included muscle weakness, ankle fracture, anxiety, and insomnia.

Resident #10 was a recent admission to the facility and a resident assessment was not due for completion. Her nursing admission assessment performed on 4/8/16 coded her as having been able to make her needs known and also coded her as requiring extensive assistance of one staff member for her activities of daily living.

Resident #10 was observed on 4/13/16 in her room sitting in her wheelchair. There was a cast to her left lower leg and at the time, she was complaining of wanting to return to bed. Resident #10 was assisted back to her bed with the help of a CNA (certified nursing assistant) and her left leg was positioned on top of a pillow for elevation. Resident #22 talked about wanting to heal and return home.

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Review of Resident #10's clinical record revealed a physician order for Clonazepam Tablet .5mg (milligram) to be given at bedtime for anxiety/sleep, Dated 4/8/16.

Review of the eMAR (electronic medication administration record) revealed an entry of documenting the administration of the Clonazepam. There was a code '9'-See Progress Note, documented on 4/8, 4/9, and 4/10.

Review of the Progress Notes regarding the Clonazepam revealed:
1. 4/8/16 at 9:33 p.m. - Awaiting Pharmacy Delivery.
2. 4/9/16 at 10:15 p.m. - Called Pharm and Script not received. Nurse to find Script and Refax.
3. 4/10/16 at 10:21 p.m. - MD (medical doctor) notified of no Script from hospital, will obtain script from MD.

Review of the hospital documentation revealed Resident #22 was administered Clonazepam during her hospitalization (4/5/16 - 4/8/16) and the Clonazepam was included in her discharge orders to the facility.

Review of Resident #10's clinical recorded revealed a Physician's Admission Medical Care Plan (History and Physical) that was completed in the facility by the physician on 4/9/16 and included Anxiety as one of her diagnoses.

On 4/14/16 at 12:20 p.m., the Director of Nursing (DON) was informed of the three days in which Resident #10's Clonazepam was not available for administration. The DON said, "The Script for the medication should have come from the

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hospital and it did not." She added that the expectation was the residents to get their medications as ordered.

"Clonazepam is a Controlled Substance Schedule IV control medication requiring an actual paper prescription for refills due to the high potential for abuse. Do not stop taking abruptly." Nursing Drug Handbook. 2011.

The administrator, DON, ADON (assistant DON), and corporate consultant were informed of the failure of the staff to ensure Clonazepam was available for administration for Resident #10, 4/14/16 at 1:45 p.m.

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to

F 425

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL / STORE DRUGS & BIOLOGICALS

F 431

This tag is cross referenced to VAC 5-371-300 (C)

1. The corrective action for the deficient practice, the vials of insulin were discarded.
2. Those residents who have an order for insulin are at risk for the deficient practice.
3. The measures taken to prevent the re-occurrence:
   a. In-service Licensed nurses on the appropriate use and storage of insulin vials.
   b. Audit of all Med Carts for expired / undated insulin vials daily 5 days week for 3 weeks, weekly times 4 weeks , monthly times 2 months .

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	495266	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANOVER HEALTH AND REHABILITATION CENTER	8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 50	F 431	4. Facility will monitor performance through quarterly QA&A committee. 5. The date of completion will be May 20, 2016.	5/20/2016

have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure insulin vials were dated when opened and accessed on one of six medication carts (loop cart).

Locked within the "loop" medication cart, two vials of insulin were observed not dated when opened and accessed.

The findings included:

The 'loop' medication cart was observed 4/13/16 at 9:07 a.m. Located within the drawer were two vials of insulin that had been opened and accessed. One vial of Novolin N and one vial of Lantus insulin were in the top medication drawer. When observed, no date was entered on either the vial or the box.

LPN (licensed practical nurse) K, stated 4/13/16 at 9:07 a.m., the vials should be dated when the vials were opened and accessed. LPN D stated

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F 431	Continued From page 51	F 431		

there was no way to know when the vial was opened. LPN K stated the vials were good for administration for 28 days after opening.

When interviewed, the DON (director of nursing) stated 4/14/16 at 12:36 p.m., the vial should be stored in the refrigerator until needed for Resident administration. Upon opening and accessing, the vial should be dated. The DON also stated that the date should be utilized whenever the vial is taken from the refrigerator, whether it is opened or not.

Review of the facility's policy entitled "General Dose Preparation and Medication Administration" included:

"3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g. insulins, irrigation solutions, etc).

3.11.1 Facility staff may record the expiration date based on date opened on the label of medications with shortened expiration dates."

Guidance for storage of Novolin N insulin was provided at www.dailymed.nih.nlm.gov:

"Novolin N in use:

Vials

Keep at room temperature below 77°F (25°C) for up to 6 weeks (42 days).
Keep vials away from direct heat or light.
Throw away an opened vial after 6 weeks (42 days) of use, even if there is insulin left in the vial.
Unopened vials can be used until the expiration

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F 431	Continued From page 52 date on the Novolin N label, if the medicine has been stored in a refrigerator." Guidance provided for Lantus insulin at www.lantus.com revealed once opened or accessed or stored out of refrigeration, the vial should only be used for 28 days. The administrator, DON (director of nursing) and corporate consultant were informed of the failure of the staff to ensure two vials of insulin (Novolin N and Lantus) were dated when opened and accessed, 4/14/16 at 12:25 p.m. "	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS This tag is cross referenced to VAC 5-371-180 (A) 1. The corrective action for the deficient practice: The nurse was informed of the glucometers policy. The nurse cut her fingernails during Survey. 2. All resident who receive accu-checks are at risk for being affected by the deficient practice. 3. The measures taken to prevent the re-occurrence: a. In-service Licensed nurses on the appropriate cleaning of glucometers.	

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F 441	Continued From page 53	F 441		

isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure the infection control committee ensured medications were administered in a manner to prevent the spread of infection for one of six medication carts in the facility.

LPN (licensed practical nurse) B failed to clean the glucometer after use and prior to putting on the medication cart and was observed to have fingernails 3/8" to 1/2" long.

The findings included:

During medication pour and pass observation, LPN B was observed 4/12/16 beginning at 3:50 p.m. After reviewing the eMAR (electronic medication administration record) LPN B determined a Resident needed to have a fingerstick blood sugar obtained. LPN B retrieved

b. Observation of glucometers use twice a day, 5 days a week for 3 weeks.
c. In-service care giving staff on fingernail policy.
d. Observation weekly on rounds to monitor compliance.

4. Facility will monitor performance through quarterly QA&A committee.
5. The date of completion will be May 20, 2016. 5/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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the glucometer, a lancet, an alcohol pad, and a dry pad from the medication cart and entered the Resident's bedroom.

After donning a pair of gloves, LPN B cleaned the Resident's finger, dried the area, and stuck the Resident with a lancet. After obtaining the fingerstick blood sugar, utilizing the glucometer, LPN B returned to the medication cart and laid the glucometer on the top of the cart. LPN B removed her gloves, cleaned her hands with hand sanitizer, and documented the results of the fingerstick blood sugar. LPN B moved the glucometer around on the cart several times. LPN B donned a pair of gloves and cleaned the glucometer, first with an alcohol pad and then with a bleach wipe. After cleaning the glucometer, LPN B laid the glucometer back on the top of the medication cart. After a bit, LPN B picked up the glucometer and placed it back into the medication cart for storage.

LPN B stated the glucometer should be cleaned prior to placing it on the medication cart, 4/13/16 at 4:02 p.m. A glucometer is a medical device used to check a Resident's blood glucose.

Review of the facility's policy entitled "Blood Testing" included:

"2. Manufacturer's guidelines will be followed for monitoring device preparation.

6. Device must be cleaned between patients."

The manufacturer's guidelines included cleaning the meter utilizing soap and water or isopropyl alcohol. The meter should then be disinfected with a 1:10 bleach solution and should be allowed

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to dry between Resident use.

Additionally, LPN B was observed to have fingernails 3/8" to 1/2 " long.

When interviewed, 4/13/16 at 4:02 p.m., LPN B was unaware of the need for shorter fingernails as an infection control practice.

Review of the facility's policy entitled "Dress Code" included:

7. Fingernails will be kept a reasonable length to prevent injury to patients."

When interviewed, the DON (director of nursing) stated 4/13/16 at 4:45 p.m., the staff should have nails that are short and clean. The DON also stated the nails should not be chipped. When asked what was a reasonable length, the DON stated they should be short.

Guidance provided at www.cdc.gov <http://www.cdc.gov>

"Whether artificial nails contribute to transmission of health-care--associated infections is unknown. However, HCWs who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing (347--349). Whether the length of natural or artificial nails is a substantial risk factor is unknown, because the majority of bacterial growth occurs along the proximal 1 mm of the nail adjacent to subungual skin (345,347,348). Recently, an outbreak of P. aeruginosa in a neonatal intensive care unit was attributed to two nurses (one with long natural nails and one with

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long artificial nails) who carried the implicated strains of Pseudomonas spp (species). on their hands (350). Patients were substantially more likely than controls to have been cared for by the two nurses during the exposure period, indicating that colonization of long or artificial nails with Pseudomonas spp. may have contributed to causing the outbreak. Personnel wearing artificial nails also have been epidemiologically implicated in several other outbreaks of infection caused by gram-negative bacilli and yeast (351--353). Although these studies provide evidence that wearing artificial nails poses an infection hazard, additional studies are warranted."

The Infection control nurse (RN A-registered nurse), stated 4/13/16 at 10:40 a.m., LPN B should have cleaned the glucometer prior to placing it on the medication cart. RN A stated she had inserviced the nursing staff around the beginning of the year regarding infection control practices related to glucometers. RN A provided a roster of the staff attending, and LPN B had been present at the inservice. RN A further stated that during her rounds, she assessed staff for compliance with infection control practices and would do spot education if noncompliance was observed.

The administrator, DON, and corporate consultant were informed of the failure of LPN B to appropriately clean the glucometer after Resident use and prior to placing it on the medication cart and LPN B having excessively long fingernails, 4/14/16 at 12:25 p.m.

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F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 4/12/16 through 4/14/16. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey.

The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #1 through 19) and 4 closed record reviews (Residents #20 through 23).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5-371-250(F) Cross Reference to F-280
12 VAC 5-371-200 (B) Cross Reference to F-281 professional standard
12 VAC 5-371-220(B) Cross Reference to F-309
12 VAC 5-371-220 (C.1) Cross Reference to F-314
12 VAC 5-371-220 (A) Cross Reference to F-323
12 VAC 5-371-340 (A) Cross Reference to F-371
12 VAC 5-371-300(A) Cross Reference to F-425
12 VAC 5-371-300(C) Cross Reference to F-431
12 VAC 5-371-180(A) Cross Reference to F-441

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4/29/2016