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	495324	A. BUILDING _____ B. WING _____	07/20/2017

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 07/18/17 through 7/20/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 50 certified bed facility was 43 at the time of the survey. The survey sample consisted of 17 residents, 14 current Resident reviews (Resident #1 through 14) and 3 closed record reviews (Resident #15 through 17).

F 151 SS=D 483.10(b)(1)(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL

(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on group and resident interviews, staff interview and facility documentation, the facility staff failed to ensure three (3) residents (Resident # 12, #13 and #14) were given the opportunity to vote in the November 2016 presidential election.

F 151

1. The facility has updated and implemented its policy and procedure pertaining to the resident's right to vote. This was done to ensure the residents have the ability to exercise their rights without interference, coercion, discrimination, or reprisal from the facility. The Activity Director went to Resident #12, #13, and #14, as well as all other resident's currently residing in the facility and inquired if they were interested in voting in the upcoming fall elections. At this time 20 residents have expressed the desire to vote. A representative from the Registrar's office came to the facility on August 2, 2017 to assist with completing the application for absentee ballots. The updated list was given to the representative in order to ensure the residents requesting to vote will be given an opportunity to do so.
2. To ensure all residents are given the opportunity to vote in any election, the activity department will go to each resident two months prior to each election, update the list of residents choosing to vote, and assist them in obtaining an absentee ballot so they can fulfill their right. Additionally, the facility will place notices about upcoming elections into the prior month's newsletters, as well as incorporate programs into the activity calendar.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Ramos	Administrator	8/4/17

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

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The finding included:

On 07/19/17 at 1:30 p.m., during a group meeting with the residents, the surveyor asked the group about their rights such as voting; three (3) out of 9 cognitive residents stated they were never given the opportunity to vote in the November 2016 presidential election.

1. Resident #14 was originally admitted to the facility on 03/12/17 with diagnosis that included but not limited to Atrial Fibrillation (1).

Resident #14's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/17/17 coded Resident #14 on the Brief Interview for Mental Status (BIMS) a score of 15 out of a possible 15 indicating no cognitive impairment.

On 07/20/17 at approximately 8:40 a.m., an interview was conducted with Resident #14 who stated everyone should have the opportunity to vote; all I needed is for someone to say, "Here's an absentee ballot so you can vote; it was just that simple." Resident #14 stated, "I didn't realize once you come into a facility, your voting rights could be taken away from you."

Resident #14 then stated, "I really don't understand why no one even talked about the presidential election around election time, my vote may not have made a difference but dear "GOD" give me the opportunity to vote; that should have been my decision and not the facilities."

1.) A-Fib is a problem with the speed or rhythm of the heartbeat. A-Fib is the most common type of

3. The facility will monitor its compliance with this regulation by having the activity department report the status on the number of residents requesting to vote in the elections at each of the QAPI meetings.
4. All corrective actions have been completed and are currently in place on 8/4/2017

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arrhythmia. The cause is a disorder in the heart's electrical system (https://medlineplus.gov/ency/article/007365.htm).

2. Resident #12 was admitted to the facility on 7/6/15. Diagnoses for Resident # 12 included, but not limited to, high blood pressure.

The most recent Minimum Data Set with an assessment reference date of 7/8/17 coded Resident #12 with a score of 12 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired in the skills needed for daily decision making.

On 7/19/17 at 4:25 pm, Resident #12 was in her room and was interviewed in regards to resident voting rights. Resident #12 stated that she had not voted during the past presidential election and stated, "I very much wanted to vote; I very badly wanted to." She also stated that she was incapacitated in bed and the facility could have aided her to vote. Resident #12 also stated that she did not receive any information from the facility about voting.

3. Resident #13 was admitted to the facility on 9/14/16. Diagnoses for Resident #13 included, but not limited to, depression and heart failure.

The most recent Minimum Data Set with an assessment reference date of 6/25/17 coded Resident #13 with a score of 14 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident # 13's cognitive abilities for daily decision making were intact.

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On 7/19/17 at 4:50 pm, Resident #13 was in her room and was interviewed in regards to resident voting rights. Resident #13 stated that she was not given an opportunity to vote while residing at the facility. She stated that "she hated missing" the last presidential election in November 2016. She did not know who to contact then; the facility did not offer her any information in regards to voting. She stated, "If staff had assisted, I certainly would have voted."

An interview was conducted with the Administrator, Activities Director (AD) and Social Worker on 07/20/17 at approximately 10:55 a.m.; the AD stated voting is a part of the resident's admission package. She proceed to say everyone is asked verbally if they wanted to vote but during the election time period I should have done more; put up posters, issued out the absentee ballots so the resident themselves could have filled out the ballots or even receive assistance from their families. The AD was asked if she spoke about the 2016 presidential election during the election time in resident's council and she replied, "No", I should have made sure that everyone was given the opportunity to vote. The Administrator stated, "Everyone has the right to vote".

The facility administration was informed of the finding during a briefing on 07/20/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

The facility's policy: Voting Policy (Revised 07/14/2007)
Policy: In compliance with the Residents Rights, it is Seaside Health Center's responsibility to provide all necessary papers and information in

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regards for all patients to vote as per their wishes. It is up the Recreation Department to give support during this time.

Definition: All residents who request to vote in any and all elections will be able to do so by either private transportation or absentee ballot.

Procedure:
1. The voter Registrar Office of Virginia Beach will be notified so all paperwork will be sent.
2. Residents/Family members will be asked to make sure residents are registered voters and at what address. If the residents need to change to the health center the forms will be provided.
3. Absentee ballots will be filled out and/or transportation will be found for the resident (therapeutic passes will be obtained as needed).
4. If a resident is unable to fill out or sign, the Recreation Department will fill out the forms so that they may assist the resident fulfill their right.
5. If the resident has a diagnosis that consists of memory impairment this will be discussed with the family representative and the resident will be deterred from voting.
6. Residents will be provided an opportunity to review information on candidates.

Policy: Residents Rights - last revision (10/20/16)
Purpose: To support our residents in experiencing a person-centered quality of life, to provide a level of care and services to our residents that will honor and protect their rights as residents of Seaside and to uphold the resident rights as set forth by Federal and State Regulatory Agencies.

F 156 SS=C 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES F 156

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(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective

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1. Information on how to contact the resident physician or person(s) responsible for the care, a copy of the rules and regulations governing conduct during the facility stay, notices such as how to protect resident funds, eligibility for Medicaid, list of names and addresses of all pertinent State agencies and contacts, how to file a complaint with the State Survey Agency or grievances with the facility are currently contained in the Seaside Resident Handbook and/or Residency Agreement Packet, which is given to each resident upon admission into Seaside Health Center. The Administrator will provide an additional copy of the Seaside Resident Handbook to Resident #12 and review all contents within it. The Facility also provides this information on the presentation board located across from the receptionist desk. The facility staff will lower the board to a level that is more accessible to those that are wheelchair bound.
2. The Facility will continue to sit with each resident upon admission to review the contents of the Residency Agreement and Seaside Resident Handbook to ensure the resident has a full understanding of their rights and how to contact person(s) if they feel their rights have been violated.
3. The Facility will conduct chart audits to review that residents signed acknowledgement of receiving the information. All discrepancies will be reported to the QAPI committee for review and recommendations to ensure sustainable compliance.
4. Date of Completion: 8/27/2017

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services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans

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Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not

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limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for

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Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident

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representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident group interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure the information for Ombudsman and other advocacy agencies posted in the facility was accessible and readable for 1 of 17 sampled residents (Resident #12).

The facility staff failed to ensure Resident #12 was able to access and read the information for the Ombudsman and other advocacy agencies posted in the facility. Resident #12 was unable to walk and was wheelchair bound.

The findings included:

Resident #12 was admitted to the facility on 7/6/15. Diagnoses for Resident # 12 included, but not limited to, high blood pressure.

The most recent Minimum Data Set with an

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assessment reference date of 7/8/17 coded Resident #12 with a score of 12 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired in the skills needed for daily decision making.

On 7/19/17 at approximately 1:30 pm, during a group meeting with the residents, 5 of 9 cognitive residents verbalized they were unaware of how to reach the Ombudsman if they had any issues. They proceeded to say that they were not aware of the positing location of the Ombudsman number.

The information about the Ombudsman and Advocacy Agencies posting was located on the wall at the second entrance to the facility. The framed posting was not low enough for residents in wheelchairs to see or read at eye level.

On 7/19/17 at approximately 4:35 pm, an interview with Resident #12 was conducted in regards to posting of information for Ombudsman and other advocacy agencies. She stated that the information was posted at the level of people standing up but not for those in wheelchairs like her. She also stated, "If I'm sitting in my wheelchair, I'm not able to see it: It's up too high and I cannot read it."

On 7/20/17 at 9:40 am, LPN #2, Nurse Manager, was taken to the lobby to look at the posting. She stated, "Yes, it's high for residents in wheelchairs and it has tiny print. The residents will not be able to see or read these letters."

On 7/20/17 at 10:40 am, the Administrator looked at the posting and stated that they will make it "larger, lower and presentable".

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F 156	Continued From page 12 On 7/20/17, a policy addressing posting of information for advocacy agencies was requested. The Administrator stated that the facility did not have a policy. The Administrator and the Managing Director of Healthcare were made aware of these findings on 7/20/17 at approximately 3:30 pm, no further information was provided.	F 156		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280	1. The care plan for Resident #2 was updated at the time of the survey. A process has been established that will prevent future occurrences from happening. This process is: a. Will continue to have morning meetings daily. In these meetings we will discuss any occurrences that may have happened over the prior weekend or prior evening/night. b. To ensure resident-centered care planning occurs in a timely manner, all care plans will be reviewed each week at the risk management meeting for all falls. All additional updates will be completed at that time. The MDS Coordinator will be accountable for updating the care plans for all changes in conditions 2. The facility will conduct routine audits on care planning by pulling the audit reports from the BlueStep system. All discrepancies will be reported to the QAPI committee for four months for review and recommendations to ensure sustainable compliance. 3. Date of Completion: 8/27/2017	

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right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident

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and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review and clinical record review the facility staff failed to update the comprehensive care plan after a fall for 1 of 17 residents (Resident #2) in the survey sample.

The facility staff failed to revise Resident #2's comprehensive care plan to include a fall on 07/11/17.

The findings included:

Resident #2 was admitted to the nursing facility on 03/31/17. Diagnoses for Resident #2 included but not limited to Physical Debility (1) and Dementia (2).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/06/17 coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #2 with extensive assistance of two with transfers, extensive

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assistance of one with dressing, hygiene, bathing, bed mobility and toilet use and supervision with eating. Resident was also coded as having an indwelling Foley (3) catheter and always incontinent bowel.

The comprehensive care plan was reviewed on 07/19/17; the care plan did not address Resident #2's fall on 07/11/17 to include new interventions to prevent another fall.

An interview was conducted with the MDS Coordinator on 07/20/17 at approximately 10:00 a.m., who stated she was responsible for updating Resident #2's care plan after his fall on 07/11/17. The MDS Coordinator proceeded to say she was not aware of the resident's fall until the Administrator informed her on 07/19/17. The MDS Coordinator stated Residents #2's fall on 07/11/17 is now care planned but I truly should have care planned the fall prior to 7/19/17; I totally missed it.

The surveyor asked the MDS Coordinator, what is the process for updating residents care plans, and she replied, "We don't have a set in stone process but we are working on it; we no longer have clinical meetings in the morning." MDS Coordinator stated, she usually got to work around 5 a.m., and the night shift nurse would report be her from the past three (3) shifts.

The MDS Coordinator also stated she would run the documentation and incident report at least once a week but sometimes twice weekly and would care plan anything new that needs to be care planned at that time.

The facility administration was informed of the

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finding during a briefing on 07/20/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

The facility's policy: "Care Planning" (Effective Date: 06/11/17).

"Procedure: An Interdisciplinary Care Plan identifies patient's needs and establishes goals in collaboration with the patient/family/caregivers. An opportunity individualized plan is developed, reviewed, and modified throughout the patients stay to ensure optimum levels of function and independence are achieved, and discharge plans are enacted where possible.
The Interdisciplinary care Plan is revised when there is a change in condition.

1. Physical Debility is the feeling of feebleness, weakness, or loss of strength (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

2. Dementia is a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

3. Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html).

F 314 SS=D 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES F 314

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(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interviews and review of facility documentation, the facility failed to ensure the necessary treatment was provided to prevent infection and promote healing for 1 of 17 Residents (Resident # 2) in the survey sample.

Resident #2 was admitted to the nursing facility on 03/31/17. Diagnosis for Resident #2 included but not limited to Physical Debility (1) and Dementia (2) and Pressure ulcer (3) Left Heel.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/06/17, coded Resident #2 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #2 with extensive assistance of two with

F 314

1. At time of the survey LPN #1 redressed the wound as per the physician's orders to Resident #2.
2. The Director of Nursing and Unit Manager will follow the clinical staff to observe dressing changes in order to identify and prevent future occurrences of deficient practices from happening.

3. The Director of Nursing will conduct in-services to all clinical staff discussing the importance of following the physician skin care orders precisely. The in-service discussed the increase in wound care orders with the weekly wound care physician visits.
4. The Director of Nursing will report audit outcomes at the weekly risk management meetings. All discrepancies will be reported to the QAPI committee for review and recommendations to ensure sustainable compliance.
5. Date of Completion: 8/27/2017

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transfers, extensive assistance of one with dressing, hygiene, bathing, bed mobility and toilet use and supervision with eating. Resident #2 was also coded as having an indwelling Foley catheter (4) and always incontinent bowel.

A Braden scale for predicting pressure sore risk was completed on 06/23/17 with the following: sensory perception - ability to respond meaningfully to pressure-related discomfort coded completely limited, moisture degree to which skin is exposed to moisture coded occasionally moist, activity degree of physical activity coded bedfast and mobility to change and control body position coded very limited, nutrition coded probably inadequate and friction an shear coded as a problem.

Resident #2's revised Comprehensive Care Plan documented Resident #2 with potential for complications related to sacral wound ulcer and Deep Tissue Injury (DTI) (5) to left heel. The goal: wound will demonstrate healing without complications over the next 90 days. Some of the intervention/approaches to manage goal included: Treatment to areas as ordered, resident to be turned every hour due to sacral ulcer, keep linens clean, dry and wrinkle free. Monitor for and provide incontinent care 2-3 every shift and as needed.

On 07/12/17 the wound care specialist documented the wound to sacral area Stage III (6). The wound measured 3.5 x 3.0 x 0.2 cm (centimeter), with moderate amount of serosanguineous drainage. Necrotic tissue 15% with 55% granulation and 30% skin.

On 07/19/17 at approximately 9:20 a.m., Resident

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#2 was observed lying in bed on a specialty mattress in a supine position with Foley catheter to bedside drainage to right side of bed and Prevalon boots (7) applied to both feet. LPN #1 positioned resident on his left side , moved Foley catheter over to the left side of bed and catheter anchored in place.

Prior to starting wound care LPN #1 washed her hands x 23 seconds; applied gloves, removed dressing from sacral wound, removed gloves then washed hands x 25 seconds. Wound doctor was at bedside to do an assessment of wounds. The Wound MD assessed the sacral wound by observation of wound and palpating around wound. The surrounding tissue around the wound was dark red into color but skin intact. The Wound MD removed her gloves then washed her hands x 21 seconds. LPN #1 proceeded to do wound care to sacral wounds: washed hands x 19 seconds then applied gloves, cleansed wounds to sacral area with wound cleanser and wiped with 4 x 4 gauze, gloves removed, wounds cleansed again with wound cleanser, wiped with 4 x 4 gauze, Santyl (8) applied to tip of Q-tip then applied to sacral wound bed then covered with Alleyvn dressing. The LPN placed all dressings into small red bag and put in solid utility room.

Review of Resident #2's current treatment order dated 05/24/17 indicated to cleanse sacral lesion with wound cleanser, apply Santyl to base of wound lesion, cover with Calcium Alginate (9) and Allevyn (10) every day and as needed.

The sacral wound treatment order was reviewed with LPN #1 on 07/19/17 at approximately 10:40 a.m., LPN #1 stated, "I looked at Resident #2's orders before I started, I but did not see the

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Calcium Alginate in the order, I guessed I overlooked it."

The facility administration was informed of the finding during a briefing on 07/20/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

The facility's policy: "Wound Care" (Revised July 2017)
"Purpose: The purpose of this procedure guidelines for the care of wounds to promote healing.

Preparation: To include but not limited to: Verify that there is a physician's order for this procedure.

Procedure: To include but not limited to: Apply treatment as ordered."

Definitions:

1. Physical Debility is the feeling of feebleness, weakness, or loss of strength (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

2. Dementia is a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

3. Pressure ulcer is localized damage to the skin and underling soft tissue usually over a body

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prominence or related to a medical or other device. The injury can present as an intact skin or an open ulcer and may be painful. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

4. Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html).

5. Deep Tissue Pressure Injury (DTI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages).

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6. 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 (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages).

7. Prevalon boots give patients the most advanced protection against heel pressure ulcers and foot drop. Prevalon helps minimize pressure, friction and shear on your patient's feet, heels and ankles. By elevating the foot and separating the heel from the mattress, it delivers total heel pressure relief (http://www.sageproductsglobal.com/en/prevalon.cfm).

8. Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (anitbiotics<http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.

9. Alginate Dressings are composed of calcium alginate, a gelatinous and water-insoluble substance. When in contact with a wound, the calcium alginate in the dressing reacts with sodium chloride from the wound. This turns the

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F 314	Continued From page 23 dressing into a hydrophilic gel that maintains a moist environment for the wound (www.medicaldepartmentstore.com/Alginate-Dressings-s/286.htm). 10. Allevyn Adhesive Hydrocellular Foam Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foam-dressings-home.html).	F 314		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 322	1. The policy for Gastrostomy-Jejunostomy tube has been distributed to all clinical staff and they have been instructed on the importance of always checking proper placement prior to any feeding or administration of medications. 2. The facility will implement protocols pertaining to the proper care of gastrostomy-jejunostomy tube feedings. When a resident with a feeding tube is admitted into the facility the staff will initiate the protocol, which will contain the procedure for checking residual prior to feeding and medication administration. 3. The Director of Nursing and Unit Manager will have each nurse demonstrate clinical competency on tube feeding placement before care is given to patient with a gastrostomy-jejunostomy tube. 4. The Director of Nursing will report audit outcomes to the QAPI committee for review and recommendations to ensure sustainable compliance. 5. Date of Completion: 8/27/2017	

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Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure proper placement of a gastrostomy tube (G Tube) (1) for 1 of 17 sampled residents (Resident #5) prior to tube feeding and administration of medication.

The facility staff failed to check proper placement of Resident #5's gastrostomy tube prior to tube feeding and administration of a medication.

The findings included:

Resident #5 was admitted to the facility on 6/29/17. Diagnoses for Resident #5 included but not limited to, dementia (2) and heart disease.

The most recent Minimum Data Set with an assessment reference date of 7/13/17, coded Resident #5 with a score of 3 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating severe impairment in decision making abilities. Resident #5 was assessed as having a feeding tube.

During a medication pass observation on 7/19/19 at 12:25 pm, LPN (Licensed Practical Nurse) #1 administered Resident #5's tube feeding and medication as follows: Washed hands; prepared the tube feeding formula, medication and water, per physician order; placed the supplies on the overbed table; explained the procedure to the resident; positioned the resident; uncapped the tube; flushed the tube with water; administered the tube feeding; flushed the tube with water; added water to the crushed medication; administered the medication via tube; flushed the tube with water and capped the tube; removed and discarded used supplies table; cleaned the

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overbed table; and washed hands. LPN #1 did not check G tube placement prior to administering the tube feeding and medication. When asked how she would check for proper placement of a G Tube, she replied, "I would place the stethoscope (3) on the stomach and listen for the "swoosh" sound." When asked if this was a facility policy she stated, "It is standard of care." She also stated, "If the tube is not in place, food could go where it's not supposed to go; could go to a different area. I should have checked placement."

On 7/19/17 at 2:25 pm, LPN #3 was interviewed and was asked how she would check for G Tube placement and she replied, "Check for placement by aspiration or by injecting air to prevent aspiration. This is standard of practice."

On 7/19/17 at 5:25 pm, an interview was conducted with LPN #2, Nurse Manager. She was asked about her expectations in regards to nurses administering tube feedings and medications through G Tube. She stated, "First, they need to do hand hygiene, then check for tube placement. She was then asked how tube is checked for placement and she stated, "Aspirate with a syringe, push secretions back, and listen for "gurgly" noise with a stethoscope."

The Comprehensive Resident Centered Plan of Care of 7/13/17 stated, in part, as follows, "Problem: Tube feeding related to poor ability to swallow and chew related to CVA (stroke); Goal: Resident will have no aspiration, choking, signs of infection, abdominal distress/distention or weight changes of >5% per month: Approach: ...Check placement and patency of tube before feeding..."

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The Physician Order Sheet had the following orders written: "Tube Feeding: Give 300 cc (centimeters) (Brand name - feeding formula) 1.5 bolus feeds, 4 times daily. Flush tube with 50 ml. (milliliters) water before and after each feeding (8:00 am, 12:00 pm, 4:00 pm, 8:00 pm). Start date - 7/13/17.
(Brand name - pain medication) 650 mg, give 2 tablets via G Tube every 8 hours (1:00 pm, 9:00 pm, 5:00 am). Start date - 7/19/17.

On 7/19/17, the facility provided a copy of the policy titled "Gastrostomy-Jejunostomy Tube, Jejunostomy (4) Tube" with no effective date documented. It stated, "Procedure: II. To Check Placement of Tube: ...3) The placement of the tube will be checked and compare with the baseline measurement prior to each tube feeding or the administration of medication or water through a G-J tube or J tube."

The Administrator and the Managing Director of Healthcare were made aware of these findings on 7/20/17 at approximately 3:30 pm. No further information was provided

Definition:

(1) Gastrostomy tube - A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach.
(Source: https://medlineplus.gov/ency/article/002937.htm)

(2) Dementia - Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior.

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F 322	Continued From page 27 (Source: NIH U.S. National Library of Medicine : Medline Plus) (3) Stethoscope - an instrument used to detect and study sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a usually cup-shaped piece placed upon the area to be examined. (Source: http://c.merriam-webster.com/medlineplus/stethoscope) (4) Jejunostomy - the surgical formation of an opening through the abdominal wall into the jejunum, a section of the small intestine. (Source: http://c.merriam-webster.com/medlineplus/jejunostomy	F 322		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323	1. The facility conducted an audit of the chart of Resident #7 and Resident #2 to ensure there were no further discrepancies noted in the resident's record. 2. A fall audit will be conducted on all resident's currently residing in the facility to identify others that do not have proper documentation. 3. All clinical staff will be in serviced on the proper procedure and documentation pertaining to falls. An investigation and audit will be conducted after every fall by the Director of Nursing and/or Unit Manager to ensure the incident report is completed in its entirety, all person(s) have been properly notified, and documentation is completed in the EMR as per policy. 4. The Director of Nursing will report audit outcomes to the QAPI committee for review and recommendations to ensure sustainable compliance. 5. Date of Completion: 8/27/2017	

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(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure follow-up assessments were completed post-fall for 2 of 17 residents in the survey sample (Resident #2 and Resident #7).

The facility staff failed to complete the follow-up assessments post fall for Resident #2 and Resident #7. There was no documentation of these assessments in the Nurses Notes.

The findings included:

1. Resident #7 was admitted to the facility on 8/24/15. Diagnoses for Resident #7 included but not limited to, depression, anxiety disorder and high blood pressure.

The annual Minimum Data Set with an assessment reference date of 2/15/17, coded Resident #7 with a score of 5 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating severe impairment in decision making abilities. Resident #7 was assessed as needing extensive assistance and one person physical assist in bed mobility, transfer, dressing, toilet use and hygiene; total dependence with one person physical assist with bathing. Resident #7 was always incontinent of bowel and bladder.

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Resident #7's Fall Risk Assessment dated 5/17/17 indicated that Resident #7 had a total score of 9 out of 10 (a total score above 10 represents high risk for falls).

On 7/19/17 at 6:30 pm, the Administrator was interviewed and stated that she "couldn't produce" the follow-up documentation for Resident #7's fall on 5/31/17. She stated, "If it's not documented, it's not done. I can't prove that it was done." The facility practice, according the Administrator, was for nurses to document follow-up notes every shift for 72 hours after a fall.

On 7/20/17 at 9:30 am, LPN (Licensed Practical Nurse) #2, Nurse Manager, was interviewed regarding the facility fall process. She stated, "When a resident falls, the nurse checks the vital signs and assesses the resident for any injuries. For unwitnessed falls, the nurses do neuro checks (1) on the resident initially and three days after the fall. The nurse continues to follow up and monitor the resident for changes in condition on the day of the fall and on the following 3 days. The nurses should document the incident in the Nurses Notes including the follow up assessments every shift for the entire 4 days."

LPN #2 was asked to describe Resident #7's fall incident. She stated that on 5/31/17 at 8:40 am, Resident #7 was reaching for something and slid off his chair. The chair alarm went off and the CNA (Certified Nurse Aide) responded and found Resident #7 on the floor.

The Comprehensive Resident Centered Plan of Care was updated on 6/5/17. It noted that on

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5/31/17, Resident #7 was transferred to the local Emergency Department and found no fracture. The plan of care documented the following: "Goal: The resident will have no avoidable falls over the next 90 days; Approach: ...Keep needed items, water, etc. in reach; Call light close and answer promptly; Ensure resident's call light is within reach and encourage the resident to use it for assistance as needed; Anticipate and meet the resident's needs with frequent monitoring to ensure wants/needs are met..."

The facility "Fall Risk Policy" with an effective date of 6/1/17, stated, "Purpose: To protect and safeguard residents from injury and decrease the incidence of falls." It stated, in part, as follows, "Procedure:...3) In the event a fall does occur, : a) Complete and document a thorough assessment and determine if any injuries are present; b) Initiate and complete neuro checks for suspected head or other injuries;...e) Document fall incident in (brand name of an electronic medical record)."

The above findings were discussed with the Administrator and Managing Director of Healthcare on 7/20/17 at approximately 3:30 pm. No further information was provided.

Definition:

(1) Neuro check - neurological assessments include (at a minimum) pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength. (Source: http://www.hcpro.com/LTC-287387-10704/Neurological-checks-for-head-injuries.htm

2. Resident #2 was admitted to the nursing

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facility on 03/31/17. Diagnosis for Resident #2 included but not limited to Physical Debility (1) and Dementia (2).

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/06/17, coded the resident with an 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #2 with extensive assistance of two with transfers, extensive assistance of one with dressing, hygiene, bathing, bed mobility and toilet use and supervision with eating. Resident #2 was also coded as having an indwelling Foley (3) catheter and always incontinent bowel.

A Fall Assessment was completed on 04/01/17; a resident is determined high risk if score of 10 or above, Resident #2's score was 12.

The comprehensive care plan documented Resident #2 with the potential for injury related to (r/t) falls secondary to dementia with decreased safety awareness along with daily medications and overall disease and aging processes. The goal: the resident will not sustain serious injury r/t fall through next review. Some of the intervention/approaches to manage goal included: keep needed items, water, etc. in reach, monitor resident for steadiness and balance and monitor for side effects from medications, labs, appetite and as a cause for falls.

Review of the facility's fall report for the past 60 days indicated that Resident #2 had a fall on 07/11/17. The review of Resident #2's clinical

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record was absent for any documentation that a fall occurred on 07/11/17.

On 07/20/17 at approximately 3:15 p.m., the Administrator stated, "Resident #2 had a fall on 07/11/17 but was unable to locate any documentation in his clinical recording indicating the nurses followed up with an assessment after his fall on 07/11/17. The Administrator stated, "I expect for all nurses do complete an assessment with a follow up nurses' note every shift x 72 hours after any fall."

The facility's policy: "Fall Risk" (Effective Date: 06/01/17).

"Purpose: To protect and safeguard residents from injury and decrease the incidents of falls.
Procedure:
3. In the event of a fall does occur:
a. Complete and document a thorough assessment and determine if any injuries are present.
b. Initiate and complete neuro checks for suspected head or other injuries.
c. Notify MD
d. Notify family representative.
e. Document fall in incident in Blue Step.

4. Review circumstances of the event to determine what additional interventions should be implemented."

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F 431 SS=D 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in

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§483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

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

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

1. No resident was identified to have received the PPD using the TB solution found in the medication cart. However, to ensure that the proper results were obtained the facility conducted an audit on all resident that potentially could have received a test using the vial dated 7/16/2017.
2. The facility conducted an audit to identify all residents that were administered a PPD skin test between the dates of 7/16/17 through 7/18/17 at 4:45pm. All residents identified were given a follow-up tuberculin skin test and all were found to have negative results.
3. An in-service was provided to all nurses about the policy for the storage and refrigeration of the PPD serum. Emphasis was placed on returning the PPD vial to the refrigerator immediately after administration.
4. An in-service was provided to all nurses regarding medication safety and the importance of locking the medication carts whenever staff walk away from them. Unit Manager will conduct spot audits to ensure medication carts remain locked.
5. The Director of Nursing will report audit outcomes to the QAPI committee for review and recommendations to ensure sustainable compliance.
6. Date of Completion: 8/27/2017

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(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and facility documentation review the facility staff failed to ensure an opened multidose vial (Purified Protein Derivative) PPD-Aplisol (for tuberculosis testing) was stored in its designated area and one (1) medication cart was locked when not in direct site.

1. The facility staff failed to ensure PPD solution was stored in the medication refrigerator on Unit 1.

2. The facility staff failed to ensure medication cart was locked when not in direct site (Unit 1).

The findings include:

1. On 07/18/17 at approximately 4:45 p.m., an open multi-dose vial of PPD solution dated 07/16/17 when open was observed on medication cart 3. RN #1 stated, "PPD solution should not be stored on the medication cart, it's usually in the medication refrigerator; not sure why it's on this cart."

An interview was conducted with the Director of Nursing (DON) on 07/18/17 at approximately 5:30 p.m., who stated she expected for the nurses to

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store the PPD solution in the medication refrigerator in the container labeled just for PPD solution only. The surveyor asked if the medication cart held a temperature between 36 to 46 degrees Fahrenheit (F), she replied, "No, it does not."

On 07/18/17 at approximately 5:45 p.m., the surveyor and DON went into the medication room, opened up the medication refrigerator and there was a purple plastic container labeled just for PPD serum only.

The facility administration was informed of the finding during a briefing on 07/20/17 at approximately 3:15 p.m. No additional information was provided.

PPD Manufactures guidelines: "This product should be stored between 36 to 46 degrees F and protect from light."

The facilities policy titled: "Tuberculin Storage" "Policy: To ensure the tuberculin (sometimes called "PPD") is stored as per manufacture's guidelines.

Procedure:
1. Store tuberculin at 35 to 46 degrees F and protect it from the light (keep in original packaging).
2. Use a stand-alone refrigerator designated for storing tuberculin, vaccine, and medical. General Storage Procedures: 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors."

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2. On 07/19/17 at approximately 9:10 a.m., LPN #4's medication cart was unlocked and left unattended when not in direct site of the nurse. The surveyor and the Administrator were standing at the medication cart when LPN #4 returned to cart, the LPN stated "I thought my cart was locked when I walked away; I should have made sure my cart was locked."

The surveyor asked the Administrator, "What is your expectation for your nurses when the medication cart is not in their direct view, the Administrator stated she expected for all nurses to double check their medication cart prior to walking away to make sure their carts are lock.

The facility administration was informed of the finding during a briefing on 07/20/17 at approximately 3:15 p.m. No additional information was provided.

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

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

F 441 SS=D 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS F 441

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at

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a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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1. Resident #10 and #11 were monitored for a seven day period for signs and symptoms of infection.
2. An audit was conducted to identify all residents that required glucose checks and that were tested by RN#1. All residents were monitored for a seven day period for signs and symptoms of infection.
3. All staff have been redirected on infection control regarding:
a. Safe bagging of linens
b. Disposal of trash
c. Handwashing.
d. Isolation precautions
4. The Director of Nursing and Unit Manager conducted a review of the policy regarding universal precautions with all staff regarding the use of equipment on multiple patients. The equipment reviewed were glucometers, vital sign machines, scales, hoyer and sera lifts. Training was conducted on handwashing after any contact of bodily fluids instead of the use of hand sanitizer.
5. The Director of Nursing and Unit Manager will conduct random audits to ensure staff compliance. The Director of Nursing will report audit outcomes to the QAPI committee for review and recommendations to ensure sustainable compliance.
6. Date of Completion: 8/27/2017

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(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interview, the facility staff failed to implement infection control practices to prevent the transmission of disease and infections for two of 17 residents in the survey sample, Resident #10 and #11; and the proper disposal of trash.

1. On 07/18/17 during a medication pass and pour observation RN (registered nurse) #1 failed to clean and disinfect the glucometer (1) before placing the glucometer back in the medication cart and between blood sugar checks obtained for Resident # 10 and #11.

2. On 07/18/17 CNA (certified nursing assistant) # 1 was observed exiting a resident room carrying a bag of trash. CNA #1 was then observed

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placing the bag of trash directly on the floor of another resident's room.

The findings included:

1. On 07/18/17 at approximately 4:35 p.m., during a medication pass and pour observation RN (registered nurse) #1 was observed entering Resident #10's room carrying alcohol pads, 4 x 4 gauzes, one (1) lancet, test strips and a glucometer machine. RN #1 cleaned Resident #10's finger with an alcohol pad, pricked the residents finger with a lancet and then used the glucometer to obtain the residents blood sugar reading. After obtaining the blood sugar check, RN #1, placed the glucometer in the medication cart without cleaning and disinfecting the glucometer.

On 07/18/17 at approximately 4:45 p.m., RN #1 was observed removing the glucometer machine (that had not been cleaned after obtaining Resident #10's blood sugar), alcohol pads, 4 x 4 gauzes, one (1) lancet, test strips. RN #1 entered Resident #11's room carrying the above supplies. RN #1 then sat down in the chair by Resident #11 and placed the alcohol pad, lancet, 4 x 4 gauzes and glucometer machine in her lap on her clothes. RN #1 cleaned Resident #11's finger with an alcohol pad, pricked the residents finger with a lancet and then used the glucometer to obtain the residents blood sugar reading. After obtaining the blood sugar check, RN #1, placed the glucometer in the medication cart without cleaning or disinfecting the glucometer.

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An interview was conducted with Director of Nursing (DON) on 07/18/17 at approximately 5:30 p.m. When the DON was informed of the above observations, she stated an area should have been cleaned, and the items for blood sugar checks should have been placed on the clean surface. The DON stated the glucometer should have been wiped down before placing the machine back in the treatment cart.

Resident #10 was admitted to the facility on 06/23/17. Diagnosis included but not limited to: Type II Diabetes (2). The current Minimum Data Set (MDS) a quarterly assessment with an assessment reference date (ARD) of 07/07/17 coded Resident #10 as scoring a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #10 had no cognitive impairment.

Resident #11 was admitted to the facility on 03/13/17. Diagnosis included but not limited to: Type II Diabetes. The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 03/30/17 coded Resident #11 with a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.

The facility administration was informed of the finding during a briefing on 7/20/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

2. On 07/18/17 at approximately 4:50 p.m., CNA (certified nursing assistant) # 1 was observed

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exiting room 101 carrying a bag of trash in her left hand. CNA #1 then walked into room #102 and threw the bag of trash in the corner next to the bathroom. When asked if there is a designated area for trash, CAN #1 replied, "I should have taken the trash directly to the trash room. At approximately 4:53 p.m., RN (registered nurse) #1 was interviewed and informed of the above observation. When asked about the process or procedure for handling a bag of trash, RN #1 stated, "The CNA should have taken the trash immediately to the soiled utility room, trash never goes on the floor."

On 07/18/17 approximately 5:35 p.m., an interview was conducted with the DON. When informed of the above observations, the DON stated the CNA should have taken the bag of trash to the biohazard room for disposal.

The facility administration was informed of the finding during a briefing on 7/20/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

Definitions:

1. Glucometer is a device that uses a small drop of blood to measure your blood sugar level. Some glucose meters measure a drop of blood taken from your finger using a special lancet device (https://www.drugs.com/cg/how-to-check-your-blood-sugar-aftercare-instructions.html).

2. Type II Diabetes Mellitus is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

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F 518 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY SS=D PROCEDURES/DRILLS

The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and facility documentation the facility staff failed to ensure all staff member were able to verbalize the proper use of a fire extinguisher.

The findings included:

On 07/19/17 at approximately 4:20 p.m., an interview was conducted with the Social Worker (SW) on emergency preparedness. The SW was asked how to use a fire extinguisher, she replied, "Honestly, I don't know, I should definitely know how to use a fire extinguisher but I definitely don't know."

The facility administration was informed of the finding during a briefing on 7/20/17 at approximately 3:15 p.m. The Administrator stated the social worker received education during her new employee orientation on Disaster Preparedness. The Administrator presented the surveyor the SW's Evacuation Chair Training and Disaster Preparedness form that was signed and dated as completed on 05/10/17.

The facility's Fire Plan for Seaside Health Center included but not limited to:

1. Rescue anyone in immediate danger while

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1. No residents were identified to have been affected by the staff not being able to verbalize the proper use of a fire extinguisher.
2. An in-service was conducted on the proper use of the fire extinguisher. This education will be provided after each routine fire drill.
3. The facility purchased and distributed information tags to all staff spotlighting RACE/PASS to help ensure staff continue to understand the proper procedure for fire safety. Staff will be tested on fire safety knowledge periodically to ensure compliance.
4. A report on staff knowledge of fire safety will be given to the QAPI committee for review and recommendations to ensure sustainable compliance.
5. Date of Completion: 8/27/2017

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protecting the safety of the rescuing staff member(s). Follow the facility's procedure for RACE, PASS and other urgent response to fire.

Appendix G - Fire Emergency

The two most important actions employees are familiar with in the initial moments of fire used as easy to remember acronyms. The first step is R.AC.E., and the second, if time permits is P.A.S.S.

P.A.S.S.
Pull the pin
Aim at the base of the fire
Squeeze the handle, and
Sweep