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SENTARA NSG CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey conducted 06/14 /16 through 06/16/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life safety Code Inspection/report will follow. The census in this 90 bed certified facility was 84 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents #1 through #14) and three closed records (Residents #15 through #17).	F 000		
F 314 SS=D	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 observations, staff interviews and clinical record review the facility staff failed to provide the necessary care and treatment for 1 of 17 residents in the survey sample to promote pressure sore healing and prevent infection, Resident #2. Resident #2 had four pressure sores. a stage IV	F 314	1. Gel cushion was placed in resident #2 geri-chair during survey to help with tissue load management to promote healing. During survey after dressing changed observed by surveyor LPN #13 was r eeducated on proper dressing changes and techniques to prevent infection. 2. All residents with pressure ulcers have the potential to be affected.	

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Administrator 6-30-2016

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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to the sacrum, an unstageable to the right hip, a stage IV to the upper back and an unstageable to the lower back.

1. During the survey days Resident #2 was observed sitting up in a geri-chair without a support system for appropriate tissue load management to promote healing.

The term tissue load refers to the distribution of pressure, friction, and shear on tissue. Quick Reference Guide for Clinicians Number 15-Pressure Ulcer Treatment by the U.S. Department of Health and Human Services.

2. The nurse failed to implement appropriate infection control practices during the dressing change observation conducted on 6/15/16 to prevent infection.

A stage IV pressure sore is described as a full thickness tissue with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often include undermining and tunneling.

An unstageable pressure sore is not stageable due to coverage of wound bed by slough and/or eschar.

The findings included:

1. Resident #2 was admitted to the facility on 7/27/15 with diagnosis to include pressure sores. The resident was on palliative care.

Palliative care is a multidisciplinary approach to specialized medical care for people with serious illnesses. It focuses on providing patients with

3. The Clinical Manager and/or designee will identify all residents with pressure ulcers to ensure they have appropriate support system when out of bed. All nursing staff will be in-serviced on appropriate use of support systems for residents with pressure ulcers. All RN's and LPN's will be educated on proper dressing changes to prevent infection.

4. Clinical Manager and/or designee will monitor all residents with pressure ulcers for proper support system when out of bed three times a weekly for 6 weeks. Clinical Manager and/or designee will observe 10% of dressing changes for proper technique three times a week for 6 weeks. Audit results will be reported at monthly QAPI meeting.

5. Completion date of 7/25/2016

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relief from the symptoms, pain, physical stress, and mental stress of a serious illness-whatever the diagnosis. The goal of such therapy is to improve quality of life for both the patient and the family. www.webmd.com/palliative-care/what-is-palliative-care.

The significant change in status MDS (Minimum Data Set) with an assessment reference date of 10/2/15 coded the resident as scoring a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired daily decision making skills. The resident was dependent on two staff for bed mobility, and transfers. Resident #2 weighed 82 pounds. The resident was at risk for pressure sore development and coded to have one stage IV and two unstageable pressure sores. Under section M1200. Skin and Ulcer Treatments A. Pressure reducing device for chair was left blank.

The comprehensive plan of care with effective date of 3/30/16 included the pressure ulcer to the sacrum and the right hip. The care plan did not include a cushion to the chair while sitting up.

On 6/14/16 during the initial tour of the facility at 12:15 p.m., and at 3:00 p.m., the resident was observed sitting reclined in a geri-chair in the dining/activity room on unit one. There was no support system on the geri-chair.

On 6/15/16 at 10:05 a.m., Resident #2 was observed sitting reclined in a geri-chair in the dining/activity room on unit one. There was no support system on the geri-chair.

The licensed practical nurse (LPN#13) assigned

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to care for Resident #2 on 6/15/16 at 5:20 p.m., was questioned about the observations of the lack of a support system for the resident's geri-chair such as a gel cushion. The LPN stated, "She should have one on, I will get an order, I am sure we have some stored in house".

The above findings was shared with the Administrator and the Director Of Nursing (DON) during the pre-exit meeting conducted on 6/16/16 at 1:50 p.m. The DON's response was, "She should have her gel cushion on...".

According to the Quick Reference Guide for Clinicians Number 15-Pressure Ulcer Treatment by the U.S. Department of Health and Human Services read, in part: The goal of tissue load management is to create an environment that enhances soft tissue viability and promotes healing of the pressure ulcer(s). Tissue load management can be achieved through the vigilant use of proper positioning techniques and support surfaces whether the individuals is in bed or in a chair.

2. The nurse failed to implement appropriate infection control practices during the dressing change observation conducted on 6/15/16 to prevent cross contamination and prevent infection.

The Weekly Skin Condition Progress Report dated 6/10/16 documented the size of the right hip and sacral pressure sores. The right hip was measured at 5.5 cm (centimeters) x 5.5 cm x 2.7 cm in depth. The sacral pressure ulcer measured 5 cm x 5 cm x 1.8 cm in depth.

The current treatment orders for the pressure

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sores read, in part:
Right hip wound-clean with 1/4 strength Dakins, apply Santyl (an enzymatic debriding agent) to 1/4 sheet of Mesalt (a debrider used to clean moderately to heavily exuding (oozing or draining) wounds, including infected wounds), place fluffed Dakins soaked moistened 4 x 4 gauze over, cover with folded ABD, secure with single piece of hypafix (tape), protect with large OPSITE (clear adhesive dressing).
Sacral wound-cleanse with 1/4 strength Dakins, apply skin prep to intact skin, place a piece of Aquacel AG large enough to slide into the undermining and fold over the upper edge, cover with folded ABD (dressing), secure with single piece of hypafix (tape), protect with large OPSITE (clear adhesive dressing).

A dressing change observation of the right hip and sacral pressure sores was conducted on 6/15/16 from 11:20 a.m. to 12:45 p.m., with LPN #13. During the dressing change the nurse failed to maintain appropriate infection control practices to prevent infection of the pressure sores and cross-contamination of medical supplies as follows:

a. After entering the resident room with dressing supplies the nurse placed the supplies on a upholstered chair located at the foot of Resident #2's bed. The nozzle of the 1/4 strength Dakins spray bottle was observed coming into contact with the fabric of the chair. The nurse cleansed off the bedside table and transferred the supplies onto it. The nurse used the Dakins spray bottle to clean the right hip pressure sore and the sacral pressure sore. The nurse failed to sanitize the nozzle prior to use.

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b. During the right hip and sacral cleansing of the wounds the nurse was observed on six separate occasions reaching into the bundle package of gauze with soiled gloves from wound secretions.

c. While packing the sacral wound the Aquacel AG dressing was observed coming into contact with the bed linen (cloth chux).

The right hip pressure sore wound bed was observed to be 75% covered with thick yellow slough (dead tissue) with a scant odor. The sacral pressure sore wound bed was pink.

After the dressing change, the bundle package of 4 x 4 gauze was placed back into the resident's closet inside a large white paper bag that contained other dressing supplies.

The nurse was interviewed on 6/15/16 at 5:20 p.m. The above observations were shared. LPN #13 stated, "I should not have kept grabbing inside the package (of 4 x 4 gauze) with my gloves, because it's cross-contaminating the other gauze in the package...I should have took out what I thought I needed and placed them on the clean field...or took off the gloves...I should have placed the Dakins on top of the bedside table instead of the chair..." The nurse stated she was not aware that the Aquacel AG dressing had come into contact with the residents linen.

The dressing change observation was shared with the Administrator and the Director Of Nursing (DON) during the pre-exit meeting conducted on 6/16/16 at 1:50 p.m. The DON stated, "She (LPN #13) should not have reached back into the package with dirty gloves".

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F 314	Continued From page 6 According to the Quick Reference Guide for Clinicians Number 15-Pressure Ulcer Treatment by the U.S. Department of Health and Human Services read, in part: Infection Control: Keeping dressings clean. Procedures to keep dressings clean and prevent cross-contamination should be established and rigorously adhered to. These procedures include the following: a. "Clean" bundled dressings-Measures include keeping dressings in the original package or in other plastic packaging...discarding the entire package if any of the dressings become wet, contaminated or dirty. b. Prior to the dressing or treatment, only the number of dressings necessary for each dressing change should be removed from containers. Once the hands of the care giver are soiled with wound secretions, they should not come into with the remaining clean dressings and other supplies until the gloves are removed and hands are washed. The facility was provided an opportunity to submit additional information prior to exit. No additional information was provided.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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This REQUIREMENT is not met as evidenced by:
Based on observations, resident interviews, staff interviews, facility documentation reviews, clinical record reviews, and in the course of a complaint investigation, the facility staff failed for one (1) resident (Resident #4) of 17 residents in the survey sample to ensure the care of a suprapubic (SP- a surgically created connection between the urinary bladder and the skin which is used to drain urine from the bladder in individuals with obstruction of normal urinary flow) catheter was provided to prevent potential complications. Resident #4's suprapubic catheter bag was observed on the floor out of it's protective cover. The findings included:
Resident #4 was admitted on 10/21/15. Diagnoses for Resident #4 included but are not limited to Benign Prostatatic Hyperplasia (BPH-benign enlargement of the prostate (a gland surrounding the neck of the bladder) and Non Alzheimer's Dementia.

The Quarterly MDS (Minimum Data Set - an assessment protocol) with an ARD (Assessment Reference Date) of 5/6/16 coded Resident #4 as having a BIMS (Brief Interview for Mental Status) score of 14 of 15 indicating no impairment of cognition. In addition, the Quarterly MDS coded Resident #4 as requiring extensive assistance with one staff person assistance for Bathing. The Quarterly MDS coded Resident #4 as requiring extensive assistance with 2 staff person assistance for Transfers, Dressing, Hygiene and Toileting.

Resident #4's Current Care Plan documented the

F315 D

1. Resident #4 catheter bag was removed from floor and placed in dignity cover.
2. All residents with catheters have the potential to be affected.
3. All Certified and Licensed nursing staff will be educated on policy of catheter care.
4. Clinical Manager and/or designee will monitor all residents with catheters daily for 2 weeks then weekly for 3 weeks to ensure drainage bags are off floor. Audits will be reported at monthly QAPI meeting.

5 Completion date of 7/25/2016

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following problem:
At risk for infection related to supra pubic catheter related to urinary retention.
Resident #4's Care Plan Goal date is documented 8/10/16.
Resident #4's current Care Plan Interventions documented the following:
Record output per shift
Clean around catheter with soap and water
Change drainage bag weekly starting 5/6/16
Keep tubing below level of bladder and free of kinks or twists
Report any sign of infection
Wash hands before and after procedure

Resident #4's Treatment Administration Record (TAR) documents the following: "Suprapubic cath care q (every) shift By Shift Starting 05/15/16 Order Date: 05/15/15.
Urine specimen results collected 4/17/16 documented: Urine WBC* (White Blood Count) 10-20 Abnormal with reference range of Negative, 0-2.
* Medline Plus documents that White Blood Cells are not normally found in the urine. Abnormal results may indicate a Urinary Tract Infection.
Resident #4's 4/17/16 Urine Culture Preliminary Report documented the following:
Greater than 100,000 organisms/milliliter Proteus Mirabilis (bacteria type)
Greater than 100,000 organisms/milliliter Gram Negative Rods

A notation on the lab report indicated that Resident #4 was on Bactrim (Medline Plus documented Bactrim is used to treat certain bacterial infections, such as pneumonia (a lung infection), bronchitis, and infections of the urinary tract, ears, and intestines.)

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An observation of Resident #4's SP drainage bag on 6/15/16 at approximately 10:35 a.m. was made. The SP drainage bag was observed lying flat on the floor. The SP drainage bag was observed not in a protective cover.

An observation of Resident #4's SP drainage bag on 6/16/16 at approximately 10:00 a.m., prior to a scheduled observation of SP care, was observed lying flat on the floor. LPN (Licensed Practical Nurse) #26 was observed to come into Resident #4's room, wash her hands, don gloves and pick the SP drainage bag off the floor to empty it. LPN #4 stated, "300 milliliters of urine out. There was some odor." LPN #4, proceeded to place the SP drainage bag onto the bed frame so it did not touch the floor. LPN #4, emptied the urine, removed gloves and washed hands. LPN #4 when asked about placement of the bag stated, "The bag should not be on the floor, it can lead to infections."

An observation of Resident #4's skin surrounding the SP catheter insertion site was made on 6/16/16 at approximately 10:15 a.m. The skin surrounding the insertion site was observed to be clean and without signs and symptoms of infection.

An interview with CNA #16 (Certified Nursing Assistant) assigned to Resident #4 for 6/16/16 was conducted at approximately 10:20 a.m. when she walked into Resident #4's room. CNA #16 stated, "Bag should be off the floor so that it won't cause an infection." CNA #16 proceeded to state, "First time coming into this room today."

An interview on 6/15/16 at approximately 1:45

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F 315	Continued From page 10 a.m. with the Director of Nurses (DON) #2 was conducted. The DON stated, "Per our standards, the bag shouldn't be on the floor." The Policy and Procedure titled, Catheter: Urinary - Care / Maintenance with a revision date of 7/9/13 documented the following: "Purpose: Catheter care is performed appropriately to prevent complications caused by the presence of an indwelling urethral catheter." The Center for Disease Control (CDC) "Catheter Associated Urinary Tract Infection Guidelines" (CAUTI) documented the following: Core Prevention Strategies: Keep collecting bag below level of bladder at all times (do not rest bag on floor) Empty collecting bag regularly using a separate, clean container for each patient. Ensure drainage spigot does not contact nonsterile container. The facility administration consisting of the Administrator and the DON were informed of the findings during a briefing on 6/16/16 at approximately 2:00 p.m. The facility did not present any further information about the findings.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff	F 332		

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interviews, facility documentation reviews, clinical record reviews, and in the course of a complaint investigation, the facility staff failed for 2 residents (Residents #11 and #12) of 17 residents in the survey sample to ensure that it was free of medication error rate of 5% or greater. The facility had 31 medication opportunities with three errors resulting in a medication error rate of 9.67 %.

The findings included:

1. Resident #11 was admitted to the facility on 5/26/16. Diagnoses for Resident #11 included but are not limited to Chronic Obstructive Pulmonary Disease (COPD) with an acute exacerbation and Generalized Muscle Weakness.

Resident #11's 14 day Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 6/9/16 coded Resident #11 as having a BIMS (Brief Interview for Mental Status) score of 14 of 15 indicating no cognitive impairment.

A. During an observation of medication pass on 6/15/16 at approximately 9:15 a.m. Resident #11 was administered Advair 250/50 Diskus two puffs by LPN (Licensed Practical Nurse) #27. The Advair Diskus was observed given to Resident #11 without any instructions. Resident #11 took the first puff and immediately took the second puff prior to returning the Advair Diskus back to the LPN.

A document titled, "VIEW" attached to the Medication Administration Record and Physician Order Statement documented the following:

1. Resident #11 did not receive medication correctly per manufacturer guidelines and right dose of medication as ordered per MD. Resident #12 did not receive all medications per medication administration record. Nurses were educated on medication administration procedures.
2. All residents receiving medication have the potential to be affected.
3. All licensed LPN's and RN's staff will be educated regarding medication administration for inhalers and nasal spray.
4. Director of Nursing and/or designee will conduct medication observation audits 2 times a week for 8 weeks. Audit results will be reported at monthly QAPI meeting.
5. Completion date of 7/25/2016

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"USES: This product is used to control and prevent symptoms (wheezing and shortness of breath) caused by asthma or ongoing lung disease (chronic obstructive pulmonary disease-COPD, which includes chronic bronchitis and emphysema).... HOW TO USE: ... wait at least 1 minute between the use of each medication, and use this drug last. ..." LPN #27 did not administer the Advair Diskus last as indicated in the instructions. LPN #27 was observed to administer on 6/15/16 at approximately 9:17 a.m. Resident #11 Spiriva 1 capsule taking 2 separate inhalations.
Medline Plus documents the use of Spiriva as followed: "used to prevent wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to air sacs in the lungs)."

LPN #27 on 6/15/16 at approximately 9:45 a.m. stated, "I wasn't aware of that (VIEW attachments giving specific instructions). And not aware of time to wait between puffs and medications."

B. Resident #11's Physician order for Azelastine HCl 137 mcg (microgram) (0.1 %) (1 nasal spray) Aerosol spray with pump intranasal. Notes: Instructions: 1 spray in each nostril two times a day.
Medline Plus documents Azelastine HCl is used "to treat hay fever and allergy symptoms including runny nose, sneezing, and itchy nose."

Resident #11's June 2016 MAR (Medication Administration Record) documented, "Azelastine

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HCl 137 mcg (microgram) (0.1 %) (1 spray) Aerosol, spray with pump Intranasal two times daily. It documented in a comment section, "Instructions: 2 sprays in each nostril).

During an observation of medication pass on 6/15/16 at approximately 9:18 a.m., LPN #27 was observed to administer Azelastine Nasal Solution 2 sprays to each nostril to Resident #11 after the Resident stated, "I get one spray to each side." LPN #27 initially administered 1 spray to each nostril for Resident #11, then went back to the MAR (Medication Administration Record) to recheck and then proceeded to give the second spray to each nostril. The surveyor prior to the second spray of Azelastine asked, "When you have a discrepancy on your MAR, what should you do?" LPN #27 pointed to the MAR and stated, "It says here on the box to give one spray to each nostril, but it says here (MAR comments) give two sprays to each side." LPN #27 did not check the Physician Order for clarification of the Azelastine.

The Policy and Procedure, titled "Medication Administration" with a revision date of 3/12/13 documented, "Medications will be administered in accordance with prescribed orders, manufacturers' specifications regarding the preparation and administration of the drug or biological and accepted professional standards and principles."

The facility administration consisting of the Administrator and the DON were informed of the findings during a briefing on 6/16/16 at approximately 2:00 p.m. The facility did not present any further information about the findings.

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2. The facility staff failed to apply an ordered medication patch (Lidocaine 5%) for Resident #12 during a medication pass observation conducted on 6/14/16. The patch was not available.

Resident #12 was admitted to the facility on 3/9/15 with diagnosis to include right flank mid-back pain.

The current MDS (Minimum Data Set) with an assessment reference date of 4/1/16 coded the resident as scoring an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS). Under Section J. Health Conditions the resident was coded as having had pain in the past 5 days. The pain frequency was almost frequently and intensity was a 5 out of a 00 to 10 pain scale.

A medication administration pass observation was conducted with Licensed Practical Nurse #12 on 6/14/16 at 4:50 p.m. The nurse looked inside the medication cart for a Lidocaine 5% patch for Resident #12. After looking and not finding it, the nurse stated, "I will have to order it from the pharmacy." The nurse then went into the resident's room and informed her of the unavailability of the patch for administration. LPN #12 then looked at the resident's back and a Lidocaine patch was not on the resident.

The physician order dated 12/10/15 on the medication administration record read, in part: Lidocaine 5% adhesive patch apply 1 patch daily to R (right) flank. The patch was scheduled to be applied daily at 5:00 p.m.

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F 332	Continued From page 15 On 6/15/16 at 10:30 a.m., the resident was observed sitting in a chair at the bedside. The Lidocaine patch was not on. The resident denied pain at this time. On 6/15/16 at 10:45 a.m., the medication cart was checked. The Lidocaine patch was not found. The medication administration room was checked. Stored inside one of the drawers was an unopened box of Lidocaine patches for Resident #12, with a dispense date of 6/14/16. A pharmacy Packing Slip was provided to the inspector for the Lidocaine patch. The Package Slip was dated 6/14/16 and indicated a box of Lidocaine 5% patches were dispensed and delivered to the facility on that date. On 6/15/16 at 4:15 p.m., the unit one nurse manager was interviewed. The above findings was shared. The unit manager was asked, " Would you have expected the Lidocaine patch to have been applied when it arrived from the pharmacy?" She stated, "Yes, depending on how the order was written." The above findings was shared with the Administrator and the Director of Nursing (DON) during the pre-exit meeting conducted on 6/16/16 at 1:50 p.m. The facility was provided an opportunity to submit additional information prior to exit. No additional information was provided.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425		

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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.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and during the course of a complaint investigation the facility failed to provide pharmacy services to meet the needs for 1 of 17 residents in the survey sample, Resident #15.

The complainant alleged the facility failed to obtain the physician ordered ointment for the resident's rash for five days due to the pharmacy "dropping the ball".

The investigation evidenced a medication treatment ointment was ordered by the physician to treat the symptoms of a rash for Resident #15 on 6/22/15. The pharmacy failed to notify the facility of the need to clarify the order with the

F 425

1. The facility failed to properly ensure medication (ointment) was available for resident # 15 as ordered per MD who no longer resides at the facility.
2. All residents have the potential to be affected.
3. All licensed LPN's and RN's staff will be educated on the policy for ordering medication.
5. Clinical Manager and/or designee will verify that medications are ordered and available 3 times a weekly for 6 weeks. Audit results will be reported at monthly QAPI meeting.
5. Completion date of 7/25/2016

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physician. The clarification was due to a possible allergic reaction to one of the components in the ointment, as a result the medication was not dispensed until 6/28/15, six days later.

The findings included:

The Face Sheet indicated Resident #15 was last admitted to the facility on 1/10/14 with diagnoses to include diabetes, dementia and chronic UTIs (urinary tract infections).

A significant change in status MDS (Minimum Data Set) with an assessment reference date of 4/30/15 coded the resident as scoring a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident required extensive assistance of two staff for all activities of daily living.

On 6/22/16 the resident was seen by the Infectious Disease Specialist primarily for recurrent UTIs that were resistant to multiple antibiotics. During the visit the resident was prescribed the following order: Lotrisone cream to buttock rash-apply sparingly and rub in completely and keep area dry and clean-bid (twice a day).

The Clinical Notes Report dated 6/23/15 at 1:23 a.m., documented the resident had returned from the Infectious Disease Specialist appointment. A new order was received for the Lotrisone cream.

The Clinical Notes Report dated 6/27/15 at 2:54 p.m., read in part:"...Lortizone [sic] cream pharmacy did not fill RX (prescription). Spoke with (name of pharmacy employee) of (name of

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contracted pharmacy) who asked that I discontinue the order and fill it again due to an error on pharmacy end..."

The Treatment Administration Record (TAR) evidenced an entry dated 6/22/16 for the aforementioned Lotrisone. The nursing staff initialed entries twice a day from 6/23/15 through 6/27/15 as having applied the Lotrisone.

Due to the Clinical Notes Report dated 6/27/15 when the pharmacy stated they had not filled the order and the discrepancy of staff signing off that the Lotrisone was applied from 6/23/15 through 6/27/15 further investigation was conducted.

The facility was asked for a Fill History of the Lotrisone for Resident #15.

The Fill History was faxed from the pharmacy on 6/15/16 to the facility for review.

The Fill History evidenced the generic brand of the Lotrisone cream (Clotrimazole-Betamethasone 1-0.05%) was initially filled and dispensed on 6/28/15, six days after the physician order was written.

An interview with the pharmacy technician was conducted on 6/16/16 at 10:30 a.m., was conducted. The pharmacy technician verified that the Lotrisone cream was not originally filled until 6/28/15. This was due to the need of a physician clarification due to the resident having an allergy to corticoid steroids (Betamethasone one of the ingredients in the cream is a steroid). The pharmacy technician stated, "We needed clarification from the physician to fill the order". The pharmacy technician further stated it was the

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responsibility of the pharmacy to have contacted the facility to obtain a clarification order. The pharmacy failed to do this, as a result the Lotrisone cream was not filled or dispensed until notified by the nurse on 6/27/15 as mentioned above.

The above findings were shared with the Administrator and the Director Of Nursing (DON) during the pre-exit meeting conducted on 6/16/16 at 1:50 p.m.

The facility was provided an opportunity to submit additional information prior to exit. No additional information was provided.

COMPLAINT DEFICIENCY

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

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

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locked compartments under proper temperature controls, and permit only authorized personnel to 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 interviews, clinical record review and facility document review the facility staff failed to ensure all drugs were stored safely and securely for 1 of 17 residents in the survey sample, Resident #2.

The Santyl (an enzymatic debriding ointment) was observed to be stored inside the resident's closet.

The findings included:

Resident #2 was admitted to the facility on 7/27/15 with diagnosis to include pressure sores. The resident was on palliative care.

Palliative care is a multidisciplinary approach to specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness-whatever

F 431

1. The facility failed to ensure treatment medication ointment was stored in locked compartment which only authorized personnel have access to the key. Resident #2 treatment medication ointment was removed from room and placed in treatment cart immediately.
2. All residents that have treatment medication ointments have the potential to be affected.
3. All licensed LPN's and RN's staff will be educated on the policy of medication storage.
4. Clinical Manager and/or designee will audit 10% Wound treatment medications five times a week for 6 weeks to ensure proper storage. Audit results will be reported at monthly QAPI meeting.
5. Completion date of 7/25/2016

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the diagnosis. The goal of such therapy is to improve quality of life for both the patient and the family.
www.webmd.com/palliative-care/what-is-palliative-care.

The significant change in status MDS (Minimum Data Set) with an assessment reference date of 10/2/15 coded the resident as scoring a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired daily decision making skills. The resident was at risk for pressure sore development and coded to have one stage IV and two unstageable pressure sores.

The current treatment orders for the right hip pressure sore read, in part:
Right hip wound-clean with 1/4 strength Dakins, apply Santyl to 1/4 sheet of Mesalt (a debrider used to clean moderately to heavily exuding (oozing or draining) wounds, including infected wounds), place fluffed Dakins soaked moistened 4 x 4 gauze over, cover with folded ABD (dressing), secure with single piece of hypafix (tape), protect with large OPSITE (clear adhesive dressing).

A dressing change observation of the right hip and sacral pressure sores was conducted on 6/15/16 from 11:20 a.m. to 12:45 p.m., with LPN #13. After obtaining some dressing supplies from the treatment cart the nurse carried them down to the resident's room and placed them on a chair. After cleaning the bedside table the dressing supplies were transferred to the clean barrier on the bedside table. The nurse then opened the resident's closet and obtained several other dressing supplies from inside a large white paper

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bag. Stored inside the white paper bag were various other dressing supplies such as hypafix tape, a 4 x 4 bundle package of gauze, Mesalt dressings, bandage scissors and a 1/2 used tube of Santyl. The tube of Santyl was used for the dressing change and then discarded into the trash.

The nurse was interviewed on 6/15/16 at 5:20 p.m. The above observation of the dressing supplies and the Santyl (an enzymatic debriding ointment) stored inside the resident closet was shared. LPN #13 stated, "I could not find the Santyl inside the treatment cart, so I looked inside the white bag and it was there...it should be stored inside the treatment cart."

The above findings was shared with the Administrator and the Director of Nursing (DON) during the pre-exit meeting conducted on 6/16/16 at 1:50 p.m. The DON's response was, "The Santyl should be stored inside the medication room inside the treatment cart."

The facility's policy and procedure titled Storage of Medications revised 7/8/2014 read, in part: Medications, treatments, and biologicals are stored safely, securely, and properly following manufacturer's recommendations or facility policy. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

The facility was provided an opportunity to submit additional information prior to exit. No additional information was provided.

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F 441 SS=D	Continued From page 23 483.65 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 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.	F 441 F 441	1. Nurse failed to follow proper hand washing techniques for resident #7 during dressing change. Nurse was immediately educated on proper hand washing technique. 2. All residents have the potential to be affected. 3. All staff will be educated on proper hand washing procedures and techniques. 4. Clinical Manager and/or designee will observe 5 staff members weekly for 6 weeks to ensure proper hand washing procedures and techniques are being followed. Audit results will be reported at monthly QAPI meeting. 5. Completion date of 7/25/2016	

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This REQUIREMENT is not met as evidenced by:
Based on observations, resident interview, staff interviews, facility documentation reviews, clinical record reviews, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #7) of 17 Residents in the survey sample to ensure the infection control practice of handwashing was utilized to prevent the spread of infection.

The findings included:

Resident #7 was admitted to the facility on 6/9/16. Diagnoses included but are not limited to Diabetic Ulcer to Left ankle.

An observation was made of Resident #7's Left medial ankle on 6/16/16 at approximately 10:30 a.m. Licensed Practical Nurse (LPN) #26 was observed to wash hands, explain procedure to Resident #7, assess pain level, clean table with an antiseptic wipe, and apply barrier. LPN #26 washed hands again, donned gloves and removed Resident #7's dressing to Left ankle. The skin to left leg above dressing was observed to be extremely scaly. LPN #26 washed hands, and cleansed Left ankle wound with normal saline. LPN #26 then removed gloves, put on another pair of gloves and applied adherent gauze and covered with aquacel AG over the top. As LPN #26 began to wrap gauze around Resident #26's ankle, the surveyor asked what type of care was done to the scaly skin on the leg above the left ankle ulcer. LPN #26 stated, "I don't know, but I can find out." LPN #26 took off her gloves and went out of the room. No hand

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washing was observed prior to LPN #26 leaving the room or when she returned to the room. LPN #26 returned with Unit Manager RN #7. RN #7 washed hands, donned gloves, and was assessing the leg when RN #8 walked in. RN #8 took lead of wound care and directed LPN #26 to get lotion for leg. LPN
#26 looked in the bedside table and obtained lotion and squeezed a small amount onto RN #8's gloved hands. RN #8 applied lotion to Resident #11's left lower leg. LPN #26 then applied gloves without handwashing and applied adherent gauze and covered with aquacel AG over the top and secured with Kling gauze.

The surveyor observed a reddened area to Resident #11's mid left lower leg. After LPN #26 did not comment on this area, surveyor asked LPN #26 to describe the area. looked at it. RN #8 stated, "Stage I Pressure Ulcer to Right Lower Leg." LPN #26 then asked if it was blanchable, and assessed the area and stated, "It's non blanchable." RN #8 stated, "We will have to begin to assess the new area."

RN #8 removed the foam dressing from the bunion and then cleaned with a skin prep pad and covered with a foam dressing. RN #8 removed gloves and left room. Prior to her leaving, she was asked about handwashing prior to wound care. She stated, "I always use the hall alcohol." LPN #26, then proceeded to place dressings and saline back into plastic bag of wound care supplies and removed barrier.

The Surveyor informed LPN #26 that handwashing was not done prior to resuming wound care after going to ask Unit Manager about the dry scaly skin. Also, handwashing was

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	495392	A. BUILDING _____ B. WING _____	C 06/16/2016

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F 441	Continued From page 26 not performed after LPN #26 removed a soiled dressing from the Left ankle wound and then opening bedside table drawer to look for lotion. LPN #26 stated, "I didn't wash hands then. I was told to wash my hands before I started, after I took off old dressing and when I finished." The Policy and Procedure titled, Life Care - Hand Hygiene with a revision date of 6/12/15 documented the following: "Purpose: Guidelines are provided for proper and effective hand hygiene to prevent transmission of infections. Appropriate 20 second hand washing must be performed under the following conditions: Whenever hands are obviously soiled. Before performing invasive procedures After handling soiled items Before performing resident care" The facility administration consisting of the Administrator and the DON (Director of Nursing) were informed of the findings during a briefing on 6/16/16 at approximately 2:00 p.m. The facility did not present any further information about the findings.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	1. Resident # 11 and # 15 records were not accurate. Resident # 11 medication order was immediately corrected, and Resident # 15 no longer resides in facility.	

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services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and during the course of a complaint investigation the facility failed to ensure the clinical record was accurate for 1 of 17 residents in the survey sample, Resident #15.

The nursing staff had initialed the Treatment Administration Record for June 2015, that Lotrisone cream was applied twice day from 6/23/15 through 6/27/15, when in fact the Lotrisone cream had not been filled/ dispensed and was not available until 6/28/15.

The findings included:

The Face Sheet indicated Resident #15 was last admitted to the facility on 1/10/14 with diagnoses to include diabetes, dementia and chronic UTIs (urinary tract infections).

A significant change in status MDS (Minimum Data Set) with an assessment reference date of 4/30/15 coded the resident as scoring a 4 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident required extensive assistance of two staff for all activities of daily living.

On 6/22/16 the resident was seen by the Infectious Disease Specialist primarily for recurrent UTIs that were resistant to multiple

2. All residents have the potential to be affected.
3. All licensed LPN's and RN's staff will be educated on the policy of transcription of orders and documentation of medications.

5. Clinical Manager and/or designee will audit 10% of new orders 5 times a week for 6 weeks. Audit results will be reported at monthly QAPI meeting.

5. Completion date of 7/25/2016

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antibiotics. During the visit the resident was prescribed the following order: Lotrisone cream to buttock rash-apply sparingly and rub in completely and keep area dry and clean-bid (twice a day).

The Clinical Notes Report dated 6/23/15 at 1:23 a.m., documented the resident had returned from the Infectious Disease Specialist appointment. A new order was received for the Lotrisone cream.

The Clinical Notes Report dated 6/27/15 at 2:54 p.m., read in part:"...Lortizone [sic] cream pharmacy did not fill RX (prescription). Spoke with (name of pharmacy employee) of (name of contracted pharmacy) who asked that I discontinue the order and fill it again due to an error on pharmacy end..."

The Treatment Administration Record (TAR) evidenced an entry dated 6/22/16 for the aforementioned Lotrisone. The nursing staff initialed entries twice a day from 6/23/15 through 6/27/15 as having applied the Lotrisone.

Due to the Clinical Notes Report dated 6/27/15 when the pharmacy stated they had not filled the order and the discrepancy of staff signing off that the Lotrisone was applied from 6/23/15 through 6/27/15 further investigation was conducted.

The facility was asked for a Fill History of the Lotrisone for Resident #15.

The Fill History was faxed from the pharmacy on 6/15/16 to the facility for review.

The Fill History evidenced the generic brand of the Lotrisone cream

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(Clotrimazole-Betamethasone 1-0.05%) was initially filled and dispensed on 6/28/15, six days after the physician order was written.

An interview with the pharmacy technician was conducted on 6/16/16 at 10:30 a.m.. The pharmacy technician verified that the Lotrisone cream was not originally filled until 6/28/15. This was due to the need of a physician clarification due to the resident having an allergy to corticoid steroids (Betamethasone one of the ingredients in the cream is a steroid). The pharmacy technician stated, "We needed clarification from the physician to fill the order." The pharmacy technician further stated it was the responsibility of the pharmacy to have contacted the facility to obtain a clarification order. The pharmacy failed to do this, as a result the Lotrisone cream was not filled or dispensed until notified by the nurse on 6/27/15 as mentioned above.

The above findings was shared with the Administrator and the Director Of Nursing (DON) during the pre-exit meeting conducted on 6/16/16 at 1:50 p.m.

The facility was provided an opportunity to submit additional information prior to exit. No additional information was provided.

COMPLAINT DEFICIENCY

Based on observations, facility documentation reviews, clinical record reviews, and in the course of a complaint investigation, the facility staff failed

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for one resident (Resident #11) of 17 Residents in the survey sample to ensure that the Medication Administration Record (MAR) was accurate for the Medication Azelastine Nasal Spray.

The findings included:

Resident #11 was admitted to the facility on 5/26/16. Diagnoses for Resident #11 included but are not limited to Chronic Obstructive Pulmonary Disease (COPD) with an acute exacerbation and Generalized Muscle Weakness.

Resident #11's 14 day Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 6/9/16 coded Resident #11 as having a BIMS (Brief Interview for Mental Status) score of 14 of 15 indicating no cognitive impairment.

Resident #11's Physician order for Azelastine HCl 137 mcg (microgram) (0.1 %) (1 nasal spray) Aerosol spray with pump intranasal. Notes: Instructions: 1 spray in each nostril two times a day. Medline Plus documents Azelastine HCl is used "to treat hay fever and allergy symptoms including runny nose, sneezing, and itchy nose."

Resident #11's June MAR (Medication Administration Record) documented, "Azelastine HCl 137 mcg (microgram) (0.1 %) (1 spray) Aerosol, spray with pump Intranasal two times daily. It documented in a comment section, "Instructions: 2 sprays in each nostril."

During an observation of medication pass on 6/15/16 at approximately 9:18 a.m., LPN #27 was observed to administer Azelastine Nasal Solution 2 sprays to each nostril to Resident #11 after the

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Resident stated, "I get one spray to each side." LPN #27 initially administered 1 spray to each nostril for Resident #11, then went back to the MAR (Medication Administration Record) to recheck and then proceeded to give the second spray to each nostril. The surveyor prior to the second spray of Azelastine, asked, "When you have a discrepancy on your MAR, what should you do?" LPN #27 pointed to the MAR and stated, "It says here on the box to give one spray to each nostril, but it says here (MAR comments) give two sprays to each side." LPN #27 did not check the Physician Order for clarification of the Azelastine.

The Policy and Procedure, titled "Medication Administration" with a revision date of 3/12/13 documented, "Medications will be administered in accordance with prescribed orders, manufacturers' specifications regarding the preparation and administration of the drug or biological and accepted professional standards and principles."

The facility administration consisting of the Administrator and the DON were informed of the findings during a briefing on 6/16/16 at approximately 2:00 p.m. The facility did not present any further information about the findings.