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SITTER AND BARFOOT VETERANS CARE CENTER	**1601 BROADROCK BLVD** **RICHMOND, VA 23224**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/24/17 through 10/26/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 200 certified bed facility was 192 at the time of the survey. The survey sample consisted of 26 current resident reviews (Residents #1 through #26) and 3 closed record reviews (Residents #29 through #29).	F 000		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to follow professional standards of practice for 3 residents (Resident #3, #7 and #1) in a survey sample of 29 residents. 1. For Resident #3, facility staff changed the documentation on a weekly skin check form. 2. Resident #7 had multiple areas where physician ordered treatments were not documented as administered.	F 281	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Skin sheets were reviewed for resident #3. There were two of the same sheet for the same time period noted. The Right Heel of resident #3 has resolved. b. MD was notified treatments were not documented for resident #7 on 11/14/17	12/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/15/2017

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

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F 281	Continued From page 1 3. Resident #1 had multiple areas where physician ordered treatments were not documented as administered. The findings included: 1. For Resident #3, facility staff altered documentation on a weekly skin check sheet. Resident #3, an 86 year old, was admitted to the facility on 9/6/16. His diagnoses included hypertension, diabetes, dementia, chronic obstructive pulmonary disease, and a mood disorder. His most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 8/30/17. He was coded with moderate cognitive impairment and required extensive assistance with his activities of daily living. He was coded to have two pressure ulcers. On 10/25/17 during the afternoon, the weekly skin check form with the dates 3/13/17, 3/20/17 and 3/27/17 was copied. The weekly skin form included the instructions "Mark diagram with all skin conditions each week." For the date of 3/20/17, both heels were circled on the diagram. On 10/26/17, the Administrator provided a copy of the same weekly skin check form. For the date of 3/20/17, both heels were circled on the diagram. In addition, the document had been altered to include the words "R. small open" next to the right heel. While in the presence of the Administrator, both forms were compared. The Administrator stated	F 281	with no new orders. c. MD was notified treatments were not documented for resident #1 on 11/14/17 with no new orders. 2. Address how the facility will identify other residents having the potential to be affected by the deficient practice: a. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a. Nurses will be re-educated on correct / accurate documentation, timeliness of documentation, and completion of documentation of treatments. b. Unit Managers will review skin observation books weekly for documentation. c. Charge nurses will check their TARs for complete documentation prior to leaving for the shift. D. Nursing managers will review TARs weekly for possible omissions in documentation. Nurses will be educated as needed if discrepancies are noted. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: a. The QA nurse / designee will audit four charts a month for three months for skin observation sheets and TARs for possible omissions and duplicates. b. Results of the audits will be brought	

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she did not know who had changed the form.

Guidance provided by Nursing Fundamentals, Chapter 3, read "Overview of Communication" page 76, section D, item 5 (e) Appropriateness "documentation should only include information that relates to the clients current healthcare status and care being delivered." Item 6 (c), altering someone else's notes, read: "the record is a legal document and entries must not be altered once recorded."

2. Resident #7 had multiple areas where physician ordered treatments were not documented as administered.

Resident #7, a 93 year-old male, was admitted to the facility on 8/19/2013. His diagnoses included dementia, osteoporosis, vitamin D deficiency, depression, hypothyroidism, and osteoarthritis.

Resident #7's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/1/2017 was coded as a quarterly assessment. Resident #7 was coded a BIMS (Brief Interview of Mental Status) score of 9/15 indicating moderate cognitive impairment. Resident #7 was also coded as needing only supervision in his activities of daily living, and as being always continent of bowel and occasionally incontinent of bladder.

A review of the clinical record was conducted on 10/25/2017 at 9:45 AM and it revealed TARs (Treatment Administration Records) for August and September 2017 showing no documentation for the following treatments per physician orders

to the QA committee for three months to determine if further action is needed.

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F 281	Continued From page 3 on the dates and times indicated: "Check wanderguard placement every shift" 8/10-day shift, 9/15-night shift "Sensor alarm to bed. Check for placement and function every shift" 8/10-day shift, 9/15-night shift "Sensor alarm to chair. Check for placement and function every shift" 8/10-day shift, 9/15-night shift "Left forearm cleanse with normal saline, pat dry skin prep to periwound apply aquacel ag with allevyn every day shift Wednesday and Saturday" 9/27-day shift "Left upper arm cleanse with normal saline, pat dry, skin prep periwound, apply aquacel ag with allevyn every day shift Wednesday and Saturday" 9/27-day shift "Calmoseptine ointment apply to sacrum topically every shift for preventative and PRN (as needed) for redness" 9/15-night shift These discrepancies were presented to Administration A, Facility Administrator, and Administration B, Director of Nursing during the end of day meeting on 10/25/2017 at 4:15 PM. On 10/26/2017 at 1:30 PM Administration A stated that she had no reason for the omissions. The facility cited Lippincott as the source for their nursing standards. "Chart-Smart: The A-Z Guide to Nursing Documentation" Lippincott/Williams page 9 stated "In all areas of the health care practice, complete and timely documentation of a patient's care	F 281		

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remains a key factor in achieving positive treatment outcomes".

Administration was informed of the findings on 10/26/2017 at 4:00 PM

3. Resident #1 had multiple areas where physician ordered treatments were not documented as administered.

Resident #1, a 90 year-old male was admitted to the facility on 9/20/2017. His diagnoses included atrial fibrillation, anemia, diabetes, benign prostatetic hypertrophy, coronary artery disease, congestive heart failure, depression, dysphagia, bilateral hearing loss, bladder dysfunction, and neurogenic bladder.

Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/4/2017 was coded as a 14-day assessment. Resident #1 was coded a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment. Resident #1 required extensive assistance of one person for his activities of daily living and was occasionally incontinent of bowel. He used a Foley catheter for urinary elimination.

A review of the clinical record was conducted on 10/24/2017 at 4:35 PM, and it revealed TARs (Treatment Administration Records) for October 2017 showing no documentation as having been completed for the following treatments per physician orders on the dates and times indicated:

"Oxygen concentrator filter-remove, rinse, dry,

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every Wednesday night shift" 10/25-night shift

"Oxygen tubing change every Wednesday night shift" 10/25-night shift

"Alternating pressure mattress check for function every shift" 10/13-evening shift, 10/15-day shift.

"Monitor voiding every shift" 10/15-day shift and night shift, 10/17-day shift, 10/18-day shift.

"Sensor alarm to bed check placement and function every shift" 10/13-evening shift, 10/15-day shift

"Sensor alarm to chair check for placement and function every shift" 10/13-evening shift, 10/15-day shift

"Skin prep to left heel every shift preventative" 10/13-evening shift

Current physician orders were present for all treatments.

These discrepancies were presented to Administration A, Facility Administrator, and Administration B, Director of Nursing during the end of day meeting on 10/25/2017 at 4:15 PM. On 10/26/2017 at 1:30 PM Administration A stated that she had no reason for the omissions.

The facility cited Lippincott as the source for their nursing standards.

"Chart-Smart: The A-Z Guide to Nursing Documentation" Lippincott/Williams page 9 stated "In all areas of the health care practice, complete and timely documentation of a patient's care

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F 281	Continued From page 6 remains a key factor in achieving positive treatment outcomes". Administration was informed of the findings on 10/26/2017 at 4:00 PM	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		12/6/17

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F 309	Continued From page 7 residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide diabetic management for 1 resident (Resident #16) in the survey sample of 29 residents. The facility staff failed to administer physician ordered Novolog N Suspension (insulin) on two occasions during October, 2017. The Findings included: Resident #16 was a 72 year old who was admitted to the facility on 6/16/17. Resident #16's diagnoses included Diabetes Mellitus, Type 2, Coronary Artery Disease, Hypertension, Psychotic Disorder, and Seizure Disorder. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 10/3/17, coded Resident #16 as having been able to understand and be understood by others. His Brief Interview of Mental Status Score was 14, indicating that he was cognitively intact. On 10/24/17 at 3:30 P.M. an observation was made of Resident #16. He was sitting in a wheelchair in his room. He was dressed appropriately. He stated that he didn't always receive his medications as scheduled.	F 309	1. MD for resident #16 was notified 11/14/17 the administration of insulin was not documented twice in October. No new orders were given. 2. Residents that receive insulin have the potential to be affected. 3. a. Nurses will be educated on following physician's orders for medication administration, documentation of medication administration, and care of a diabetic resident. b. Charge nurses will check their MARs for complete documentation prior to leaving for the shift. c. Nursing managers will review MARs weekly for possible omissions in documentation. Nurses will be educated as needed if discrepancies are noted. 4. a. The QA nurse / designee will audit four charts a month for three months for possible insulin documentation omissions. b. Results of the audits will be brought to the QA committee for three months to determine if further action is needed.	

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F 309	Continued From page 8	F 309		

On 10/24/17 a review was conducted of Resident #16's clinical record, revealing the Medication Administration Record (MAR) for October, 2017. On 10/6/17, and 10/14/17 at 8:00 A.M., the Novolin N Suspension (insulin) was not documented as having been administered. In addition, the nursing notes did not contain any documentation that the blood sugar levels had been obtained or that the medication had been administered.

Resident #16's clinical record contained the following signed physician order: "10/1/17. Novolin N Suspension Inject 50 units Subcutaneously one time a day for Diabetes Mellitus."

According to a laboratory report dated 10/18/17, Resident #16's Hemoglobin A1C reading was "7.5, (indicating) Diabetic with Good Control."

On 10/24/17 a review was conducted of facility documentation, revealing an undated Blood Sugar Monitoring policy. It read, "Purpose - To monitor blood glucose levels. To regulate medications and diet in accordance with blood glucose levels." Resident #16 did not have a physician order for blood glucose monitoring.

On 10/26/17 at approximately 11:00 A.M. an interview was conducted with the Assistant Director of Nursing (RN 1). He stated, "I can't explain why he didn ' t get his insulin. It's important to monitor his blood sugar. A possible outcome of not receiving insulin is that they may become weak and dizzy."

On 10/26/17 at 2:00 P.M., the facility Administrator (Administration 1), and Director of

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F 309	Continued From page 9 Nursing (Administration 2) were informed of the findings. No further information was received.	F 309		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (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- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed for one (Resident #23) of 29 residents in the survey sample to administer a nutritional supplement per physician's order. Resident #23 was administered 30 ml's (milliliters) less than the physician ordered amount of the nutritional supplement drink, Med Pass 2.0. As described by medline.com "Med Pass 2.0 Balanced Fortified Nutrition provides a convenient way to supplement calories and	F 325	1. MD for resident #23 was notified 11/14/17 of the amount of med pass received during the survey. The resident's weight has remained stable. No new orders given. 2. Residents that receive med pass supplement have the potential to be affected. 3. a. Measuring cups that are calibrated / hold up to 240ml have been ordered.	12/6/17

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F 325	Continued From page 10 protein-Designed to be used as a medication pass drink..., delivers more nutrition than water, juice or milk-Additional intake can mean weight maintenance or weight gain." The findings included: Resident #23 was admitted to the facility on 11/4/14 with the diagnoses of, but not limited to, dementia with behavioral disturbance, dysphagia (difficulty swallowing), depression and anxiety. Resident #23 resided in the secured unit. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/3/17. The MDS coded Resident #23 with severe cognitive impairment; fluctuating inattention and disorganized thinking; physical behaviors directed toward others, other behavioral symptoms not directed toward others; and required extensive assistance from staff for all activities of daily living except bathing which he was dependent on staff for. Resident #23 was not coded for any weight loss. On 10/25/17 at approximately 9:27 a.m. during a medication administration observation, Licensed Practical Nurse-2 (LPN-2) prepared Resident #23's medications which included the nutritional supplement drink, Med Pass 2.0. She obtained a white styrofoam cup from the medication cart, shook the container of Med Pass and poured the supplement into the cup up the bottom of the wider lipped band area. Above that line was an indented line between the top of the cup opening and the bottom band area. After LPN-2 poured the Med Pass into the cup, the surveyor asked how much she poured into the cup since a	F 325	b. Nurses will be educated on the utilization of these measuring cups for use with med pass supplement administration. 4. a. Staff Development Nurse / designee will observe four nurses per month for three months on administering med pass supplement and use of the measuring cups. Education will be provided as needed. b. Staff Development nurse will report any concerns noted to the QA committee for three months to determine if further action is needed.	

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F 325	Continued From page 11 measuring cup was not used to determine to amount. LPN-2 stated "Up to line is 240 ml's." LPN-2 assisted Resident #23 to drink the supplement. On 10/25/17 at 2:00 p.m. a review of Resident #23's physician orders was conducted. The review revealed a physician's order with a start date of 7/4/17, for "Med Pass 2.0 four times a day Provide 240 ml (milliliters) QID (4 times a day)." Resident #23's October 2017 Medication Administration Record was reviewed and contained the Med Pass 2.0 directions as ordered. On 10/25/17 at 1:35 p.m. a request was made for LPN-2 to measure how much fluid would equal 240 ml's in the styrofoam cup. LPN-2 got a 30 ml measuring cup from the medication cart, a pitcher of water and a styrofoam cup. She measured 30 ml's of water into the measuring cup and poured it into the styrofoam cup 8 times which equaled 240 ml's. The 240 ml's filled the cup to the top of the inner indented line which was above the bottom lip band area where LPN-2 pour the supplement up to during the medication pass. The amount of supplement LPN-2 administered was measured to be 210 ml's and not the physician ordered 240 ml's. After the demonstration, LPN-2 stated she "Was told the cups were 240 ml's." On 10/25/17 at 4:25 p.m., the Administrator and Director of Nursing were informed of the observation and incorrect supplement amount administered.	F 325		
F 329	DRUG REGIMEN IS FREE FROM	F 329		12/6/17

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F 329 SS=D	Continued From page 12 UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral	F 329		

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	495393	A. BUILDING ______ B. WING ______	C 10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 13 interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure non-pharmacological interventions were attempted prior to administering anti-anxiety medication, Lorazepam (Ativan) for one (Resident #15) of 29 residents in the survey sample. Resident #15 received PRN (as needed) Lorazepam on 9/5/17, 9/16/17, 10/15/17, and 10/17/17 without documented evidence that non-pharmacological interventions were attempted prior to administering the medication. The findings included: Resident #15 was originally admitted to the facility on 11/11/14 and readmitted on 6/30/17 and 10/13/17 with the diagnoses of, but not limited to, chronic pain, bipolar disorder, depression and psychosis. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/26/17. The MDS coded Resident #15 with no cognitive impairment; independent with most activities of daily living; required set up assistance from staff for toileting and hygiene. On 10/24/17 at 4:30 p.m. Resident #15 was observed sitting on the edge of his bed, alert and conversational. The conversation focused his pain management and restatements on what the doctor was going to order for him. Resident #15	F 329	1. Resident #15 medications / chart will be reviewed by the Pharmacist for possible unnecessary medications. MD was also notified and stated to administer PRN med to resident when asked by resident. This has been care planned. 2. Residents that receive PRN anti-anxiety medication have the potential to be affected. 3. a. Nurses will be educated to document non-pharmalogical interventions used prior to the administration of a PRN anti-anxiety medication. b. Orders will be put into the EHR system to allow nurses to document what non-pharmalogical interventions were used prior to the PRN anti-anxiety medication being given. 4. a. The QA nurse / designee will audit four charts per month for three months to review documentation of non-pharmalogical interventions used prior to the administration of a PRN anti-anxiety medication. Nurses will be educated as needed. b. Results of the audits will be brought to the QA committee for three months to determine if further action is needed.	

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F 329	Continued From page 14 did not verbalize or show signs of anxiety during the conversation. On 10/15/17 at 4:00 p.m., Resident #15's clinical record was reviewed. The review revealed a physician's order dated 10/13/17 which read: "Lorazepam Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every 12 hours as needed for anxiety." The previous order for the PRN Lorazepam was dated 6/30/17. The Medication Administration Record for September and October 2017 was reviewed and revealed Resident #15 received the PRN Lorazepam on 9/3 at 9:45 p.m., 9/5 at 12:00 p.m., and 9/16/17 at 8:34 p.m., 10/15 at 2:50 p.m., and 10/17/17 at 1:21 p.m. Review of Resident #15's progress notes revealed non-pharmacological interventions (which included talking, dimming lights, and put on relaxing shoes) were attempted prior to administering the Resident requested Lorazepam on 9/3/17. However, there were no documented attempts for the other dates listed above. Facility policy titled "PSYCHOTROPIC MEDICATION USE" with a revised date of May 2017 included: "POLICY This facility will take all the necessary steps to ensure the appropriate usage of psychotropic medications, in order to comply with state and federal regulations governing Long-Term Care Facilities." "PROCEDURE...4. The use of scheduled and PRN psychotropic medication will be monitored for continued use and duration using State and federal Guidelines..." On 10/25/17 at approximately 4:40 p.m., the Administrator and Director of Nursing were	F 329		

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F 329	Continued From page 15 informed of the Lorazepam being administered without non-pharmacological approaches attempted.	F 329		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not 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;	F 441		12/6/17

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F 441	Continued From page 16 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed for one (Resident #23) of 29 residents in the survey sample to implement an effective infection control program.	F 441	1. The MD of resident #23 was notified on 11/14/17 with no new orders. Resident #23 has no signs / symptoms of infection. 2. All residents have the potential to be affected.	

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F 441	Continued From page 17 Resident #23 was administered his medicated and nutritional supplement drinks after the cups were placed on the floor. The findings included: Resident #23 was admitted to the facility on 11/4/14 with the diagnoses of, but not limited to, dementia with behavioral disturbance, dysphagia (difficulty swallowing), depression and anxiety. Resident #23 resided in the secured unit. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/3/17. The MDS coded Resident #23 with severe cognitive impairment; fluctuating inattention and disorganized thinking; physical behaviors directed toward others, other behavioral symptoms not directed toward others; and required extensive assistance from staff for all activities of daily living except bathing which he was dependent on staff for. On 10/25/17 at approximately 9:27 a.m. during a medication administration observation, Licensed Practical Nurse-2 (LPN-2) mixed Miralax powder in approximately 8 ounces of water in a styrofoam cup and poured the nutritional supplement drink, Med Pass 2.0, into another styrofoam cup. LPN-2 brought Resident #23's medications and fluids into the activity room, squatted down in front of Resident #23 and explained to him she had his medications. LPN-2 spoon fed him the pudding after placing one of the styrofoam cups on the floor and held the other cup in her hand. She alternated giving Resident #23 his medications and fluid. LPN-2 fed him slowly per his need and spoke to him throughout the	F 441	3. a. Nurses will be educated not to place items on the floor during medication pass. b. Nurses will be educated on infection practices during medication pass. 4. a. Staff Development Nurse / designee will observe four nurses per month for three months, observing infection control practices during medication pass. Nurses will be educated as needed. b. Staff Development nurse will report to the QA committee for three months concerns noted to determine if further action is needed.	

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F 441	Continued From page 18 administration. She placed the first cup on the floor and picked it up again to administer the contents to the resident. When he finished drinking the fluid in the first cup, LPN-2 picked the cup off the floor and assisted him to drink the contents. On 10/25/17 at 1:40 p.m. an interview was conducted with LPN-2. When the infection control observation concern was discussed LPN-2 stated she should "Not put cups on the floor." On 10/25/17 at 4:25 p.m., the Administrator and Director of Nursing were informed of the infection control concern observation.	F 441		