STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495185	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY HEALTH AND REHABILITATION CENTER	456 E MAIN ST WAVERLY, VA 23890

(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	F 000	F314	4-8-16

An unannounced Medicare/Medicaid standard survey was conducted 2/23/16 through 2/24/16 and 2/26/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey.

The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #1 through #19) and 5 closed record reviews (Residents #20 through #24).

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 observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #3) of 24 residents in the survey sample, to assess, obtain physician orders and treat a left heel ulcer.

Upon readmission to the facility on 2/5/16, the

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Resident #3 is receiving treatment to the left heel ulcer as ordered.

Skin assessments were reviewed on current residents to identify the need for a treatment, to ensure that a treatment order is in place, and to ensure that the treatment is documented and completed as ordered.

Licensed staff will be educated on:

- Assessment of residents upon admission and readmission to determine the need for treatment orders to any wound.
- Obtaining treatment orders upon admission or readmission.

The Unit Manager or designee will monitor the assessment and treatment order for residents admitted or readmitted to the facility to ensure that wounds are identified, treatment orders are obtained, and treatments are documented as ordered. Issues noted will be referred to the Quality Assessment Committee for review and recommendation.

Completion date: 4/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Audrey R Seeley	Administrator	3/14/16

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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facility staff did not assess Resident #3's left heel ulcer until 2/8/16 and failed to obtain and initiate treatment orders until 2/9/16.

The findings included:

Resident #3 was originally admitted to the facility on 8/26/15 with the diagnoses of, but not limited to, End Stage Renal Disease (ESRD) with hemodialysis, diabetes mellitus type 2, chronic stage III pressure ulcer, methicillin resistant staphylococcus aureus infection (MRSA), hypertension and congestive heart failure (CHF). Resident #3 had 5 hospitalizations due to changes in condition since admission; the most recent readmission was 2/20/16.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/21/15. A significant change MDS was in progress at the time of survey. The MDS coded Resident #3 with no cognitive impairment, required limited assistance from staff for bed mobility, transfers and toileting; required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3 was coded as independent with eating. The MDS coded Resident #3 with 1 stage 3 pressure ulcer and 1 unstageable pressure ulcer.

On 2/24/16 at 8:25 a.m., Resident #3 was observed lying across his bed with his eyes closed. His left leg was dangling off the bed. Resident #3 was wearing a thin white sock on his left foot with a visible dressing covering his heel. There was no drainage observed through the dressing or sock. Resident #3 had a right leg amputation.

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On 2/24/16 at 8:40 a.m., Resident #3's clinical record was reviewed. The review revealed a physician's order dated 2/9/16 which read: "Medihoney Wound/Burn Dressing Gel (Wound Dressings) Apply to Left heel topically in the evening...LEFT HEEL-CLEANSE WITH NS (normal saline), APPLY NO STING SKIN PREP TO PERI WOUND APPLY MEDIHONEY TO WOUND, COVER WITH GAUZE, AND WRAP IN KERILEX-Order date-02/09/2016..." Further review of the clinical record revealed Resident #3 was hospitalized on 1/15/16 due to fever, trembling, low blood pressure (90/60) and slow to respond. He had MRSA of bilateral heel wounds prior to discharge. Resident #3 was readmitted on 2/5/16 with a right leg below the knee amputation (BKA). There were no treatment or monitoring orders for his right stump (BKA). Prior to hospitalization on 1/15/16, the same treatment for his left heel wound care, as ordered above, was in effect and documented as being performed. Documentation revealed Resident #3 was originally admitted to the facility with a Stage III pressure ulcer on his left heel.

Review of the February 2016 Medication Administration Record (MAR) included the left heel treatment order and nurses initials which indicated the treatment was completed from 2/9/16 through 2/14/16 and 2/20/16 through 2/23/16 at 1800 (6:00 p.m.). There was no treatment order or documentation in the clinical record to reveal that wound care to the left heel was performed from readmission on 2/5/16 until 2/9/16.

Review of Nursing Progress Notes revealed the following documentation:

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2/5/16 at 22:31 (10:31 p.m.) included:"...recent right BKA (below the knee amputation). Dressing to RBKA and left heel, unable to do complete skin assessment this shift...."
2/6/16 21:38 (9:38 p.m.) included: "...Dressing to rt. bka is dry and intact. Dressing to lt. foot dry and intact..."
2/7/16 04:54 (4:54 a.m.) included: "...dressing dry and intact to right BKA. dressing intact to left foot..."
2/7/16 16:26 (4:26 p.m.) included: "...staples intact to R bka, no drainage or s/s (signs/symptoms) of infection noted from area..."
2/7/16 17:25 (5:25 p.m.) "...Dressing to rt. bka is dry and intact. Dressing to lt. foot dry and intact..."
2/8/16 03:53 (3:53 a.m.) "...dressing dry and intact to right bka. and dressing dry and intact to left foot..."

A "Re-Admission History and Physical" performed by Resident #3's Medical Doctor dated 2/7/16 included "...Dressing; right BKA: Clean/dry. Has dry dressing, left heel..." The hospital discharge instructions did not include orders for wound care for either wound site.

The "Wound Record (Revised)" dated 2/8/16 listed the left heel wound was present on admission, and was a Stage III pressure ulcer. The current treatment plan read: "Cleanse with NS, apply medihoney, wrap with gauze daily."

Guidance given from the National Pressure Ulcer Advisory Panel (npaup.org) described a Stage III pressure ulcer as follows:

"Category/Stage III: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may

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be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable."
On 2/26/16 at 1:40 p.m., the Administrator (Admin-A) was informed of the facility staff's delay to assess, obtain orders and treat Resident #3's left heel ulcer and no orders to treat or monitor his right stump incision site.

Review of Resident #3's care plan included the following:
"Focus *Skin impairment: left heel and right stump
Created on: 11/27/2015
Revision on: 02/06/2016

Goal *Resident will have no complications from skin impairment through next review.
Created on: 11/27/2015
Revision on: 02/06/16
Target Date: 04/06/2016

Interventions/Tasks (updated 02/06/2016)
*Contact isolation as ordered *Heels up cushion, Darco boots. *Keep skin clean and dry. *Lotion to dry skin. *Weekly Skin Assessment."

On 2/26/16 at 2:20 p.m. an interview was conducted with the Unit Manager, Admin-B. When the lack of treatment orders for Resident

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F 314	Continued From page 5 #3's left heel from 2/5/16-2/9/16 was discussed, Admin-B stated she would check into it. At 2:25 p.m., Admin-B stated "I didn't see an order until 2/9/16 like you did" then stated "If it's not documented it wasn't done." The Corporate Nurse (Admin-D) was informed of the findings on 2/26/16 at 2:35 p.m. On 2/26/16 at 4:00 p.m. an observation of Resident #3's left heel ulcer was conducted with Licensed Practical Nurse-A (LPN-A). LPN-A removed the dressing on Resident #3's heel which exposed a gauze-like dressing with approximately 2 centimeters (cm) by 2 cm of yellow red drainage. The ulcer was clean and dark red/maroon in color with approximately 0.5 cm x 0.5 cm of yellow slough in the 11:00 area of the wound. The surrounding skin was intact with no signs of irritation. There was no odor present. Resident #3 denied pain or discomfort. No further information was provided by the facility staff. Complaint Deficiency.	F 314		4-8-16
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

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by:
Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed for 1 resident (Resident #4) in a survey sample of 24 residents to provide adequate supervision.

Resident #4 fell out of bed while being changed by one Certified Nursing Assistant (CNA). Resident #4 was care planned to need assistance from two staff during activity of daily living care.

The findings included:

Resident #4, a 92 year old, was admitted to the facility on 4/19/06. Her diagnoses included dementia, diabetes, depression and kidney failure.

Resident #4's most recent Minimum Data Set (MDS) assessment was an annual assessment with an assessment reference date (ARD) of 1/15/16. She had a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment. She required extensive assistance with her activities of daily living.

On 2/26/16 at 9:20 a.m., Resident #4 was observed lying in bed. The bed alarm and fall mats were in place.

Resident #4's nursing notes were reviewed. Included was a note title "Incident Note" dated 4/13/15 23:29 (11:29 p.m.). The note read "Situation: CNA (Certified Nursing Assistant) was changing resident. Resident's legs fell off the bed, and resident slid off the edge of bed on to the floor. CNA stated "Resident landed on her knees." "Resident has a 0.2 x 0.2 skin tear on her

Resident #4 has had no fall since November 4, 2015.

Current residents were reviewed to ensure that those needing a two person assist for bed mobility or transfers are identified and are receiving the appropriate level of supervision.

Certified Nursing Assistants and licensed staff will be educated on:

- Provision of two person assist for bed mobility and transfers for residents with identified need of two person assist
- Reporting change in condition requiring increased need for assistance to Charge Nurse and/or Unit Manager

The Unit Manager or designee will monitor provision of two person assistance on a random weekly basis through observation and review of documentation. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.

Completion date: 4/8/16

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left knee, skin tear to left little toe 0.1 x 0.1. Resident denies pain or discomfort noted. Bilateral legs contracted, left hand contracted. No bruising noted at this time. ROM WNL (range of motion within normal limits). RP (responsible party) in room on other side of curtain. Resident assisted back to bed and completed adl (activity of daily living) care x 3 staff. Resident resting quietly in bed at this time, call bell within reach. MD (doctor) aware. RP aware. DON (Director of Nursing) aware. On call supervisor aware. Recommendations " 2 person assist with adls while in bed. Call for assistance."

The facility staff was asked if a fall investigation had been completed for Resident #4's fall. Facility staff provided a "Post Fall Assessment" dated 4/13/15 9:00 p.m.. The "Information" section of the form read "2. What was the resident attempting to do at the time of the fall? CNA was changing resident and resident slid out of bed." The "Resident Status" section of the form read "4. Problems with Mobility". Under section 4, the following were checked: "4a. Unsteady gait/ poor balance?" and "4c. Two person assist?".

On 2/26/16 at 10:50 a.m., the Acting Director of Nursing (ADM B) was asked during what types of care staff were expected to provide 2 person assistance. ADM B stated that if a resident required a two person assistance, than it should be provided during all activities of daily living.

On 2/26/16 at 11:00 a.m., Certified Nursing Assistant B (CNA B) was asked when working with a resident who needed a two person assist, which types of care would require a second person. CNA B stated that two staff should be

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F 323	Continued From page 8 present to perform all activities of daily living for a resident who was a two person assist. CNA A was the staff that had been working with Resident #4 during the incident. CNA A's statement dated 4/13/15 read, "I was doing rounds of (resident name). Turned her over, she slid off the bed. She landed on her knee, because I had her by her arms." Resident #4's annual MDS with an ARD of 2/6/15 was reviewed. Section G (A) "Bed Mobility" was coded as 4/3 (total dependence on staff with at least two persons physical assist). Resident #4's care plan was reviewed. A "focus" dated 9/29/14 read "The resident has an ADL self-care performance deficit r/t (related to) Limited ROM (range of motion), Activity Intolerance, Contracture." The "Interventions" read "AM (morning) Routine: The resident requires total assist." "Transfer: The resident requires total assist of 2 people." The Administrator and Corporate Nurse were notified of the issue on 2/26/16 at the end of day meeting.	F 323		4-8-16
F 332 SS=E	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 observation, staff interview, Resident	F 332		

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F 332	Continued From page 9 interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure Three Resident's medications, (Residents #15,#16, & #3) were administered with an error rate of less than 5%. The facility's medication error rate was 17% with 5 errors out of 29 opportunities, in a survey sample of 24 residents. 1. For Resident #15, on 2-24-16 during Medication pour and pass observations, the facility staff failed to administer physician ordered Lactulose, and Aspirin. 2. For Resident #16, on 2-24-16 during Medication pour and pass observations, the facility staff failed to administer physician ordered Timolol eye drops. 3. For Resident #3, on 2-24-16 during Medication pour and pass observations, the facility staff failed to administer a physician ordered Hydrocortisone suppository, and Fluticasone nasal spray. The findings included: 1. Resident #15, was initially admitted to the facility on 8-5-15. Diagnoses included; Hepatitis, Diabetes type 2, Osteomyelitis, depression, anxiety, congestive heart failure, high cholesterol, anemia, polyneuropathy, gastro-esophageal reflux disease (GERD), hypertension, morbid obesity, edema, and chronic mitral valve disease. Resident #15's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12-16-15.	F 332	F332 Resident #15 is receiving Lactulose and Aspirin as ordered. Resident #16 is receiving Timolol eye drops as ordered. The Hydrocortisone suppository and Fluticosone nasal spray were discontinued for Resident #3 on February 26, 2016. Current residents were reviewed to ensure that ordered medications are administered as ordered. Licensed staff will be educated on: • Medication administration • Documentation of medication administration • Offering of medication which resident frequently refuses • Documentation of medication refusal • Physician notification if medication is not given as ordered The Unit Manager or designee will complete random weekly observations of medication administration and documentation. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: 4/8/16	4-8-16

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The MDS coded Resident #16 with no cognitive impairment. The Resident required extensive assistance from staff for bed mobility, transfers, toileting, dressing, hygiene and bathing. Resident #15 was also coded as independent with eating, and always incontinent of bowel and bladder.

On 2-24-16 at 9:00 a.m. Resident #15 was briefly interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident was fully interviewed on 2-26-16 at 9:30 a.m.

Resident #15 was observed on 2-24-16 at 9:00 a.m. during the medication pour and pass observation receiving medications. Licensed Practical Nurse (LPN) B, reviewed the MAR (medication administration record) for Resident #15. LPN B removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer. During the medication preparations one pill was dropped on the top of the medication cart. LPN B picked up the medication with a spoon, and placed it back into the cup with the other 10 pills and administered all of them to Resident #15. LPN B pushed the following 11 pill oral medications into the medication cup, and 1 liquid oral preparation, in water in a separate cup.

1 .Lisinopril 5 mg (milligrams) one tablet. To be given at 8:00 a.m.
2. Lasix 40 mg one tablet. To be given at 8:00 a.m.
3. Glimeperide 1 mg one tablet. To be given at 8:00 a.m.
4. Metformin 850 mg one tablet. To be given at 8:00 a.m.

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5. Carvedilol 3.125 mg one tablet. To be given at 8:00 a.m.
6. Topiramate 200 mg one tablet. To be given at 8:00 a.m.
7. Escitalopram 10 mg one tablet. To be given at 8:00 a.m.
8. Gabapentin 100 mg three tablets. To be given at 8:00 a.m.
9. Pramipexole 0.25 mg one tablet. To be given at 8:00 a.m.
10. Cholestipol 1 gram two tablets. To be given at 8:00 a.m.
11. Iron sulfate 325 mg one tablet. To be given at 8:00 a.m.
12. Potassium Chloride 20 Milliequivalents (meq) one powder packet mixed by the nurse in water. To be given at 8:00 a.m.
13. Multivitamin one tablet to be given at 8:00 a.m.

LPN B and the surveyor entered Resident #15's room, and LPN B assisted the resident with taking the medications. Resident #15 accepted and swallowed all of the medications without difficulty.

Immediately following the medication pass observations, Resident #15's medication orders were reviewed and reconciled. The physicians orders revealed that all of the medications given were ordered by the physician, however, two additional medications were ordered and were not given. They are as follows;

1. Aspirin 325 mg one tablet. To be given at 8:00 a.m.
2. Lactulose 10 grams per (ml) milliliter, give 45 ml. To be given at 8:00 a.m.

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On 2-24-16 at 10:00 a.m. a copy of Resident #15's Medication Administration Record (MAR) was requested, along with the MAR's for two other Residents involved in the medication pour and pass observation errors. At 12:00 noon all 3 MAR's were received from the Director of Nursing (DON). The documents revealed that the two medications omitted for Resident #15 during medication pour and pass observation were signed by the nurse as given.

LPN B was interviewed on 2-24-16 at 12:15 p.m., and told of the medication errors. She stated she was aware of the mistakes and had documented on the MAR in error for the omitted medications, and would fix the document. None of the omitted medications had been given at this hour.

On 2-24-16, Resident #15's care plan was reviewed. The Resident's care plan stated administer medications as ordered.

The facility policy was reviewed and stated all medications would be administered as ordered by the physician.
When the Director of Nursing (DON) was asked what specific source of text is used to model their medication administration and nursing practice by, she stated " We use Potter and Perry."
Guidance was provided for appropriate documentation of physician's orders in 'Fundamentals of Nursing 7th Edition, Potter-Perry, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Once you

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determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications."

An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-24-16 at 3:30 p.m., and on 2-26-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated that LPN B had been re-educated by the Registered Nurse Staff Development Coordinator, and an inservice on Medication administration had been conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further information was provided by the facility.

2. For Resident #16, on 2-24-16 during Medication pour and pass observations, the facility staff failed to administer physician ordered Timolol eye drops.

Resident #16 was was admitted to the facility on 9-11-14 with diagnoses of, but not limited to: Diabetes Mellitus, Hypertension, GERD, Glaucoma, Pancreatitis, Idiopathic Neuropathies, and Below the Knee Amputation.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/15. Resident # 16 was coded with a brief interview for mental status score of 15 of a possible 15 points indicating no

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cognitive impairment. Resident # 16 was coded as independent in activities of daily living; and always continent of bowel and bladder.

On 2-24-16 at 9:10 a.m. Resident #16 was briefly interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident was fully interviewed on 2-26-16 by a second surveyor.

Resident #16 was observed on 2-24-16 at 9:15 a.m. during the medication pour and pass observation receiving medications. Licensed Practical Nurse (LPN) B, reviewed the MAR (medication administration record) for Resident #16. LPN B removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the following 8 pill oral medications into the medication cup.

1 Amlodipine 10 mg (milligrams) one tablet. To be given at 9:00 a.m.
2. Finasteride 5 mg one tablet. To be given at 9:00 a.m.
3. Metoprolol 50 mg one tablet. To be given at 9:00 a.m.
4. Gabapentin 300 mg two tablets. To be given at 9:00 a.m.
5. Lisinopril 20 mg one tablet. To be given at 9:00 a.m.
6. Januvia 50 mg one tablet. To be given at 9:00 a.m.
7. Hydrochlorothiazide 25 mg one tablet. To be given at 9:00 a.m.
8. Metformin 500 mg one tablet. To be given at 9:00 a.m.

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LPN B was observed to have 9 tablets total in the pill administration cup, and this was verified with LPN B. Resident #16 was in the main hallway of the facility, and insisted on receiving his medications there at the medication cart. LPN B assisted the resident with taking the medications. Resident #16 accepted and swallowed all of the medications without difficulty.

Immediately following the medication pass observations, Resident #16's medication orders were reviewed and reconciled. The physicians orders revealed that all of the medications given were ordered by the physician, however, one additional medication was ordered and was not given. The medication omitted is as follows;

1. Timoptic Solution 0.25% (timolol) instill one drop in both eyes two times per day for Glaucoma. To be given at 9:00 a.m.

On 2-24-16 at 10:00 a.m. a copy of Resident #16's Medication Administration Record (MAR) was requested, along with the MAR's for two other Residents involved in the medication pour and pass observation errors. At 12:00 noon all 3 MAR's were received from the Director of Nursing (DON). The documents revealed that the eye drop medication omitted for Resident #16 during medication pour and pass observation was signed by the nurse as given.

LPN B was interviewed on 2-24-16 at 12:15 p.m., and told of the medication errors. She stated she was aware of the mistakes and had documented on the MAR in error for the omitted medication, and would fix the document. The omitted medication had not been given at this hour.

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On 2-24-16, Resident #16's care plan was reviewed. The Resident care plan stated administer medications as ordered.

The facility policy was reviewed and stated all medications would be administered as ordered by the physician.
When the Director of Nursing (DON) was asked what specific source of text is used to model their medication administration and nursing practice by, she stated " We use Potter and Perry." Guidance was provided for appropriate documentation of physician's orders in 'Fundamentals of Nursing 7th Edition, Potter-Perry, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Once you determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications."

An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-24-16 at 3:30 p.m., and on 2-26-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated that LPN B had been re-educated by the Registered Nurse Staff Development Coordinator, and an inservice on Medication administration had been conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further information was provided by the facility.

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3. For Resident #3, on 2-24-16 during Medication pour and pass observations, the facility staff failed to administer a physician ordered Hydrocortisone suppository, and Fluticasone nasal spray.

Resident #3 was originally admitted to the facility on 8-26-15. Diagnoses included; End Stage Renal Disease (ESRD) with hemodialysis, diabetes mellitus type 2, chronic ulcer, methicillin resistant staphylococcus aureus infection, hypertension and congestive heart failure (CHF). Resident #3 had 5 hospitalizations since the original admission, with the most recent readmission being 2-20-16.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12-21-15. A significant change MDS was in progress at the time of survey. The MDS coded Resident #3 with no cognitive impairment, required limited assistance from staff for bed mobility, transfers and toileting; required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3 was coded as independent with eating.

On 2-24-16 at 9:25 a.m. Resident #3 was briefly interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident was fully interviewed by a second surveyor.

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Resident #3 was observed on 2-24-16 at 9:25 a.m. during the medication pour and pass observation receiving medications. Licensed Practical Nurse (LPN) B, reviewed the MAR (medication administration record) for Resident #3. LPN B removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the following 8 pill oral medications into the medication cup.

1 Amiodarone 200 mg (milligrams) one tablet. To be given at 9:00 a.m.
2. Clopidogrel 75 mg one tablet. To be given at 9:00 a.m.
3. Tamsulosin 0.4 mg one tablet. To be given at 9:00 a.m.
4. Metoprolol 50 mg one tablet. To be given at 9:00 a.m.
5. Cyclobenzaprine 5 mg one tablet. To be given at 9:00 a.m.
6. Colchicine 0.6 mg one tablet. To be given at 9:00 a.m.
7. Imodium 2 mg one tablet. To be given at 9:00 a.m.
8. Uloric 80 mg one tablet. To be given at 9:00 a.m.

LPN B was observed to have 8 tablets total in the pill administration cup, and this was verified with LPN B. Resident #3 was in his room with his spouse sitting at bedside. LPN B donned a yellow isolation precaution gown, and gloves, and assisted the resident with taking the medications, after obtaining the Resident's blood pressure and pulse. There was deficient practice observed in infection control precautions with regard to this Resident during the medication pour and pass observation. That information is included in a

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separate area of the statement of deficiencies (SOD 2567) report. Resident #3 accepted and swallowed all of the medications without difficulty.

Immediately following the medication pass observations, Resident #3's medication orders were reviewed and reconciled. The physicians orders revealed that all of the medications given were ordered by the physician, however, two additional medication were ordered and were not given. The medications that were omitted are as follows;

1. Hydrocortisone Acetate Suppository 25 mg insert one suppository rectally. To be given at 9:00 a.m.
2. Fluticasone Propionate 50 mcg (micrograms) one spray in each nostril. To be given at 9:00 a.m.

On 2-24-16 at 10:00 a.m. a copy of Resident #3's Medication Administration Record (MAR) was requested, along with the MAR's for two other Residents involved in the medication pour and pass observation errors. At 12:00 noon all 3 MAR's were received from the Director of Nursing (DON). The documents revealed that both medications omitted for Resident #3 during medication pour and pass observation was signed by the nurse as refused, however, neither medication was offered by the nurse during medication pour and pass observation.

LPN B was interviewed on 2-24-16 at 12:15 p.m., and told of the medication errors. She stated that Resident #3 often refused these two medications, so she didn't offer them. The omitted medications had not been given at this hour.

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F 332	Continued From page 20 On 2-24-16, Resident #3's care plan was reviewed. The Resident care plan stated administer medications as ordered. The facility policy was reviewed and stated all medications would be administered as ordered by the physician. When the Director of Nursing (DON) was asked what specific source of text is used to model their medication administration and nursing practice by, she stated " We use Potter and Perry." An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-24-16 at 3:30 p.m., and on 2-26-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated on 2-26-16, that LPN B had been re-educated by the Registered Nurse Staff Development Coordinator, the day before (2-25-16) and an inservice on Medication administration had been conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further information was provided by the facility.	F 332		4-8-16
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 21 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, facility staff failed to ensure expired medications were not available for use on one of two units. The findings included: On 2-24-16 at approximately 10:00 AM, the medication room on Unit One was inspected. The medication refrigerator contained a "Tubersol 1 milliliter vial for injection". Written on the open vial was the open date of 1-15-16, and had	F 431	F431 The expired Tubersol and Prolixin were removed from the medication storage room on February 24, 2016. Medication storage rooms on each Unit were checked to ensure that there were no expired medications present. Licensed staff will be educated on: • Monitoring of expiration dates of medication • Removal and destruction of expired medications The Unit Manager or designee will monitor the medication storage rooms on a random weekly basis to ensure that there are no expired medications present. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: 4/8/16	4-8-16

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F 431	Continued From page 22 expired 2-15-16. Also in the medication refrigerator was a 5 milliliter vial of "Prolixin 25 milligrams per milliliter" injectable, opened on 1-1-15, which expired 2-1-15, 12 months prior to survey. The Director of Nursing stated the innoculation fluid, and medication should only be kept one month after opening. Both were discarded. On 2-24-16, the Administrator and DON (director of nursing) were notified of the above findings. No further information was provided.	F 431	F441 Residents #15 and #3 are receiving medications with use of appropriate infection control methods. Administration of medications has been observed to ensure that residents are receiving medications with the use of appropriate infection control methods. Licensed staff will be educated on: • Disposal and replacement of dropped pill • Proper donning of precaution garb • Obtaining supplies from appropriate storage area • Use of disposable vital sign equipment for Residents requiring special infection control precautions • Avoiding placing items on wet surface • Appropriate storage of contaminated items • Appropriate transport of contaminated items	4-8-16
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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F 441	Continued From page 23 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to perform care and services in a manner to prevent the spread of infection for 2 Residents (Residents #15 and #3) of 24 residents in survey sample. 1. For Resident #15, the facility staff failed to maintain effective infection control practices during medication administration; Specifically, the facility staff dropped a pill on top of the medication cart, picked it up and administered it to the Resident. 2. For Resident #3, the facility staff failed to maintain effective infection control practices during medication administration; Specifically, the staff did not don isolation precaution garb properly, retrieved a box of gloves from another Resident's room to use in Resident #3's room, wrapped a contaminated stethoscope around her bare neck after use on Resident #3, laid a blood pressure cuff and stethoscope on a wet	F 441	The Unit Manager or designee will complete a random weekly observation of medication administration to ensure that proper infection control practices are followed. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: 4/8/16	4-8-16

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contaminated sink top while washing her hands, did not properly disinfect resident equipment, took contaminated devices to store in the medication cart, and contaminated trash items up the hallway to throw away in the medication cart trash can.

The findings included;

1. For Resident #15, the facility staff failed to maintain effective infection control practices during medication administration; Specifically, the facility staff dropped a pill on top of the medication cart, picked it up and administered it to the Resident.

Resident #15, was initially admitted to the facility on 8-5-15. Diagnoses included; Hepatitis, Diabetes type 2, Osteomyelitis, depression, anxiety, congestive heart failure, high cholesterol, anemia, polyneuropathy, gastro-esophageal reflux disease (GERD), hypertension, morbid obesity, edema, and chronic mitral valve disease.

Resident #15's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12-16-15. The MDS coded Resident #16 with no cognitive impairment. The Resident required extensive assistance from staff for bed mobility, transfers, toileting, dressing, hygiene and bathing. Resident #15 was also coded as independent with eating, and always incontinent of bowel and bladder.

On 2-24-16 at 9:00 a.m. Resident #15 was briefly interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation.

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The Resident was fully interviewed on 2-26-16 at 9:30 a.m.

Resident #15 was observed on 2-24-16 at 9:00 a.m. during the medication pour and pass observation receiving medications. Licensed Practical Nurse (LPN) B, reviewed the MAR (medication administration record) for Resident #15. LPN B removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed 11 oral pill medications into the medication cup, and 1 liquid oral preparation, in water in a separate cup.

During the medication preparations one pill was dropped on the top of the medication cart. LPN B picked up the medication with a spoon, and placed it back into the cup with the other 10 pills and administered all of them to Resident #15. Resident #15 accepted and swallowed all of the medications without difficulty.

Immediately following the medication pass observations, Resident #15's medication orders were reviewed and reconciled.

On 2-24-16 at 10:00 a.m. a copy of Resident #15's Medication Administration Record (MAR) was requested, along with the MAR of a second Resident, for whom infection control practices were found to be deficient. At 12:00 noon both MAR's were received from the Director of Nursing (DON).

LPN B was interviewed on 2-24-16 at 12:15 p.m., and told of the infection control deficient practice. She stated she was aware of the mistakes and would let the DON know about the situations. She stated she knew she should not have picked

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up the pill and given it.

The facility infection control policy was reviewed with the Registered Nurse Staff Development Coordinator (RNSDC), who was also responsible for the facility infection control program. The RNSDC stated "We follow the CDC guidelines for our infection control program." She was further asked if a pill is dropped during medication administration, what should the nurse do as a result. Her answer was to "discard the pill" and retrieve a new one to administer. She was asked if all staff had been educated on the standard, and she replied "yes."
An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-24-16 at 3:30 p.m., and on 2-26-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated on 2-26-16, that LPN B had been re-educated the day before (2-25-16) by the Registered Nurse Staff Development Coordinator, and an inservice on Medication administration and infection control had been conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further information was provided by the facility.

2. For Resident #3, the facility staff failed to maintain effective infection control practices during medication administration; Specifically, the staff did not don isolation precaution garb properly, retrieved a box of gloves from another

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Resident's room to use in Resident #3's room, wrapped a contaminated stethoscope around her bare neck after use on Resident #3, laid a blood pressure cuff and stethoscope on a wet contaminated sink top while washing her hands, did not properly disinfect resident equipment, took contaminated devices to store in the medication cart, and contaminated trash items up the hallway to throw away in the medication cart trash can.

Resident #3 was originally admitted to the facility on 8-26-15. Diagnoses included; End Stage Renal Disease (ESRD) with hemodialysis, diabetes mellitus type 2, chronic ulcer, methicillin resistant staphylococcus aureus (MRSA) infection, Vancomycin Resistant Blood infection (VRE), hypertension and congestive heart failure (CHF). Resident #3 had 5 hospitalizations since the original admission, with the most recent readmission being 2-20-16.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12-21-15. A significant change MDS was in progress at the time of survey. The MDS coded Resident #3 with no cognitive impairment, required limited assistance from staff for bed mobility, transfers and toileting; required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3 was coded as independent with eating.

On 2-24-16 at 9:25 a.m. Resident #3 was briefly interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident was fully interviewed by a second

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surveyor.

Resident #3 was observed on 2-24-16 at 9:25 a.m. during the medication pour and pass observation receiving medications. Licensed Practical Nurse (LPN) B, reviewed the MAR (medication administration record) for Resident #3. LPN B removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer and pushed the 8 oral pill medications into the medication cup. LPN B was asked why the isolation sign was on the Resident's door, and she replied "this Resident has VRE in the blood, and MRSA in a foot wound." methicillin-resistant Staphylococcus aureus [MRSA], vancomycin resistant enterococcus [VRE]),

LPN B was observed to have 8 tablets total in the pill administration cup, and this was verified with LPN B. LPN B left the medication cart and proceeded to Resident #3's room. The Resident was in his room with his spouse sitting at bedside. The spouse wore no isolation garb and was sitting at the bedside on a rollator walker.

LPN B donned a yellow isolation precautions gown, and gloves, and assisted the resident with taking the medications, after obtaining the Resident's blood pressure and pulse. Resident #3 accepted and swallowed all of the medications without difficulty. There was deficient practice observed in infection control precautions with regard to this Resident during the medication pour and pass observation. The observation was as follows:

On 2-24-16 at 9:25 a.m. LPN-B cleansed her hands with Iso-gel alcohol hand cleanser at the

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medication cart, which was at the nursing station, and removed a black blood pressure cuff and stethoscope from the cart, and proceeded down the hall to Resident #3's room. She laid the black blood pressure cuff and stethoscope on top of the isolation cart which was located outside of Resident #3's room. She removed a yellow stethoscope, and white blood pressure cuff, and a yellow paper fiber isolation gown, and laid them on top of the isolation cart, beside the two black devices.

Upon finding no gloves in the cart, she called to Certified Nursing Assistant (CNA) B, who was giving care in the room next door to Resident #3. LPN B asked CNA B, to "(get me a box of gloves out of that room)." CNA B came out of the next door neighbor's room with an open box, half full of gloves, and handed it to LPN B with her bare hands, and LPN B accepted them in her bare hands. LPN B then placed the gloves in one of the drawers of the isolation cart after removing 2 gloves to wear.

LPN B donned the pair of the borrowed gloves, and then donned the yellow gown, not covering both wrists of the gown with the gloves, so as to be able to see the skin of both of her wrists. LPN B entered the Resident's room with the White blood pressure cuff and yellow stethoscope, leaving the black set outside of the room on the isolation cart.

LPN B did not tie the gown in back, and so it was flapping open in the front and her clothing was directly touching the Resident, and the Resident's bed. LPN B moved around Resident #3's bed while taking a blood pressure, and pulse, and administering medications.

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Immediately after touching the Resident's bare skin with the white blood pressure cuff and yellow stethoscope, while taking the blood pressure, and pulse, LPN B wrapped the stethoscope around her bare neck touching her skin. LPN B, then laid the blood pressure cuff on the Resident's overbed table, which had not been cleaned, and contained a water cup, and personal belongings, while she administered Resident #3's medications.

LPN (Licensed Practical Nurse) B then moved over to the sink after medications were administered, and with gloved hands, took the stethoscope off of her neck, and laid the stethoscope and blood pressure cuff on the sink counter top, which was soiled and wet.

LPN B removed her gloves and gown, and threw them away in the red biohazard trash container. She then washed her hands with soap and water for 10 seconds. LPN B dried her hands with 2 paper towels. She then picked up the stethoscope and blood pressure cuff in her bare left hand, together, in the middle of the devices, with the soiled wet paper towels she had dried her hands on. Both ends of the devices were uncovered, and she proceeded out of the Resident's room with them.

LPN B then laid the soiled stethoscope and blood pressure cuff on top of the isolation cart (beside the black stethoscope and blood pressure cuff from the medication cart). The 2 yellow and white devices were still partially wrapped in the middle where she had been holding them, in the wet, soiled paper towels, with her bare left hands.

She opened the drawer of the cart and removed

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one glove from the box of borrowed gloves, and gloved her right hand. With her left hand bare, she picked up the White and yellow stethoscope and blood pressure cuff still partially wrapped in the middle by the wet soiled paper towels, and with her right gloved hand opened the isolation cart drawer which held a plastic container of sanitizing wipes for equipment.

LPN B then pulled open the pop top with her thumb on the right hand (gloved) and removed one wipe and closed the container. LPN B proceeded to wipe both the yellow and white stethoscope and blood pressure cuff 3 times each with the sanitizing wipe. She only wiped each device in the areas that were sticking out of the paper towels, as she was unable to access the parts in the towels that she was holding in her ungloved left hand.

She then opened one of the 3 drawers in the cart with her gloved hand and dropped the stethoscope and blood pressure cuff into it holding onto the paper towel in her bare left hand. She removed her one glove, wrapping the paper towels in it as she pulled it off inside out, and held it in her left hand.

LPN B then picked up the black blood pressure cuff, and stethoscope in her right hand and proceeded back up the hall to the medication cart at the nursing station and threw away the glove which held the paper towels, and placed the black devices back in the medication cart.

On 2-24-16 at 10:00 a.m. a copy of Resident #15's Medication Administration Record (MAR) was requested, along with the MAR of a second Resident, for whom infection control practices

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were found to be deficient. At 12:00 noon both MAR's were received from the Director of Nursing (DON).

LPN B was interviewed on 2-24-16 at 12:15 p.m., and told of the infection control deficient practice. She stated she was aware of the mistakes and would let the DON know about the situations.

On 2-26-16 at 11:00 a.m. the facility infection control policy was reviewed with the Registered Nurse Staff Development Coordinator (RNSDC), who was also responsible for the facility infection control program. The Isolation Precautions document followed the CDC guidelines. The RNSDC stated "We follow the CDC guidelines for our infection control program." She was asked if all staff had been educated on the standard, and she replied "yes."
The following is the guidance from the CDC; "New CDC Infection Prevention Website for Long-Term Care Facilities

The Centers for Disease Control and Prevention debuted a new website for long-term care facilities. The site provides infection prevention guidance, tools, and information for clinical staff, administrators, residents, and health department personnel specific to long-term care settings.

Available resources address topics such as surveillance (using the CDC National Healthcare Safety Network ' s Long-Term Care Module), environmental cleaning and disinfection, hand hygiene, antibiotic stewardship, and prevention of infections caused by bloodborne pathogens, C. difficile, norovirus, and multidrug-resistant organisms (MDRO's).

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Personal protective equipment (PPE). A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.
Multidrug-resistant organisms (MDROs). In general, bacteria that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents (e.g., MRSA, VRE, extended spectrum beta-lactamase [ESBL]-producing or intrinsically resistant gram-negative bacilli) 176. Epidemiologically important pathogens . Infectious agents that have one or more of the following characteristics: 1) are readily transmissible; 2) have a proclivity toward causing outbreaks; 3) may be associated with a severe outcome; or 4) are difficult to treat. Examples include; clostridium difficile, bacilli [ESBLs], methicillin-resistant Staphylococcus aureus [MRSA], vancomycin-resistant enterococci [VRE], methicillin.

Contact precaution isolation requires the use of gloves, gowns, cleaning and disinfection of the patient care environment and equipment , and hand hygiene.
Example of Safe Donning of Protective Equipment (PPE)
GOWN: Fully cover torso from neck to knees, arms to end of wrist, and wrap around the back. Fasten in back at neck and waist.
GLOVES: Use non-sterile for isolation. Select according to hand size. Extend to cover both

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wrists of isolation gown.

I.B.3.a.ii. Indirect contact transmission In-direct transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. In the absence of a point-source outbreak, it is difficult to determine how indirect transmission occurs. However, extensive evidence cited in the Guideline for Hand Hygiene in Health-Care Settings suggests that the contaminated hands of healthcare personnel are important contributors to indirect contact transmission 16. Examples of opportunities for indirect contact transmission include:

- Hands of healthcare personnel may transmit pathogens after touching an infected or colonized body site on one patient or a contaminated inanimate object, if hand hygiene is not performed before touching another patient.72, 73.
- Patient-care devices (e.g., electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients74 75-77.
- Instruments that are inadequately cleaned between patients before disinfection or sterilization (e.g., endoscopes or surgical instruments).
- Clothing, uniforms, laboratory coats, or isolation gowns used as personal protective equipment (PPE), may become contaminated with potential pathogens after care of a patient colonized or infected with an infectious agent, (e.g., MRSA 88, VRE 89, and C. difficile 90.

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Although contaminated clothing has not been implicated directly in transmission, the potential exists for soiled garments to transfer infectious agents to successive patients.

I.C.1. b. Multidrug-Resistant Organisms (MDROs) In general, MDROs are defined as microorganisms - predominantly bacteria - that are resistant to one or more classes of antimicrobial agents176. Although the names of certain MDROs suggest resistance to only one agent (e.g., methicillin-resistant Staphylococcus aureus [MRSA], vancomycin resistant enterococcus [VRE]), these pathogens are usually resistant to all but a few commercially available antimicrobial agents. This latter feature defines MDROs that are considered to be epidemiologically important and deserve special attention in healthcare facilities177.

MDROs are transmitted by the same routes as antimicrobial susceptible infectious agents. Patient-to-patient transmission in healthcare settings, usually via hands of Health Care Worker ' s, has been a major factor accounting for the increase in MDRO incidence and prevalence, especially for MRSA and VRE.

Facilities199-201. Preventing the emergence and transmission of these pathogens requires a comprehensive approach that includes administrative involvement and measures (e.g., nurse staffing, communication systems, performance improvement processes to ensure adherence to recommended infection control measures), education and training of medical and other healthcare personnel, judicious antibiotic use, comprehensive surveillance for targeted MDROs, application of infection control

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precautions during patient care, environmental measures (e.g., cleaning and disinfection of the patient care environment and equipment, dedicated single-patient-use of non-critical equipment), and decolonization therapy when appropriate.
The prevention and control of MDROs is a national priority - one that requires that all healthcare facilities and agencies assume responsibility and participate in community-wide control programs176, 177 "
An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-24-16 at 3:30 p.m., and on 2-26-16 at 3:00 p.m.. All in attendance were made aware of the findings. The DON stated on 2-26-16, that LPN B had been re-educated the day before (2-25-16) by the Registered Nurse Staff Development Coordinator, and an inservice on Medication administration and infection control had been conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further information was provided by the facility.

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE — F 514

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

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F 514	Continued From page 37 resident's assessments; the plan of care and 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 and clinical record review, the facility staff failed for one resident (Resident #3) of 24 resident's in the survey sample to maintain an accurate record. For Resident #3, the facility staff incorrectly dated a change in condition which required hospitalization. The actual change in condition occurred and was documented on 11/16/15 but a "late entry" of the condition was documented and dated for 11/15/15. The findings included: Resident #3 was originally admitted to the facility on 8/26/15 with the diagnoses of, but not limited to, End Stage Renal Disease (ESRD) with hemodialysis, diabetes mellitus type 2, chronic ulcer, methicillin resistant staphylococcus aureus infection, hypertension and congestive heart failure (CHF). Resident #3 had 5 hospitalizations since admission; the most recent readmission was 2/20/16. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/21/15. A significant change MDS was in progress at the time of survey. The MDS coded Resident #3 with no cognitive impairment, required limited assistance from staff for bed mobility, transfers and toileting;	F 514	F514 Resident #3's current medical record is accurately documented. Current residents with a noted change of condition in the past month were reviewed to ensure that their medical records were accurate. Licensed staff will be educated on: • Accurate documentation • How to document a late entry in the medical record The Unit Manager or designee will monitor accurate medical record documentation on a random weekly basis. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. Completion date: 4/8/16	4-8-16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495185	A. BUILDING _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 38	F 514		4-8-16

required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3 was coded as independent with eating.

On 2/26/16 Resident #3's clinical record was reviewed. The review revealed the following nursing Progress Notes:

"Late Entry 11/15/15 01:10 (1:10 a.m.) Type: Change in Condition SBAR (Situation-Background-Assessment-Recommendation)...Abnormal vital signs...Altered mental status Functional decline...Respiratory arrest Unresponsiveness This started on 11/15/15 during the Morning...The issues appears to be: dying. See eINTERACT Change of Condition Evaluation assessment for further information..." The note was written by Licensed Practical Nurse-A (LPN-A).

The eINTERACT is electronic document within the facility electronic documentation system that is a comprehensive change in condition evaluation.

Nursing Progress Notes also included the following:

"11/15/15 at 20:56 (10:56 p.m.)...States 'I just do not feel good'... Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest xray results and then call the results to him. Xray results call to MD and no new orders received, resident is to go to hemo-dialysis in a.m. Xray shows mild chf (congestive heart failure)..."

"11/16/15 01:19 (1:19 a.m.)...resident found in

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F 514	Continued From page 39	F 514		4/8/16

resp. distress. 911 notified. resident transported to (hospital name) ER for evaluation and treatment...resp. (respirations) down to 4 (per minute). ventilation started via ambu bag. MD. RP (responsible party) and unit manager aware..."

On 2/26/16 at 2:45 p.m. an interview was conducted with the Unit Manager (Admin-B) and the Corporate Nurse (Admin-D). The concern that nursing documentation on 11/15/15 at 1:10 a.m. described Resident#3 as "appears to be dying, respiratory arrest and unresponsiveness" yet he wasn't sent to the hospital until 11/16/15 at 1:19 a.m. was discussed. Admin-B reviewed the documentation in the computer system and explained that LPN-A put the wrong date and time of the "late entry". She stated the actual change in condition started on 11/15/15 at 20:56 (10:56 p.m.), the MD (Medical Doctor) and RP were notified and a chest xray was ordered. She stated "Then at 1:19 a.m. on 11/16/15 he declined and went to the hospital." The decline in condition did not occur on 11/15/15 at 1:10 a.m. When asked if it was just a documentation error and not a delay in sending the resident to the hospital, Admin-B replied "Yes." Admin-D agreed it was an inaccurate record.

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

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