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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5-17-16 through 5-19-16. No complaints were investigated during the survey. The facility was cited with a harm deficiency at a Past Non Compliance (PNC); No Plan of Correction is needed for this citation. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 80 certified bed facility was 71 at the time of the survey. The survey sample consisted of 16 current resident reviews (Residents #1-13 and #18-20) and 4 closed record reviews (Residents #14-17).	F 000	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to implement an effective pressure ulcer program resulting in harm for 1 resident (Resident #2) of 20 residents in the survey sample. The facility investigated the	F 314	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/8/16

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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incident, and developed a plan of correction prior to survey, resulting in a finding of Past Non-Compliance.

For Resident #2 the facility staff failed to identify a pressure ulcer prior to the area becoming a Stage III pressure ulcer.

The findings included:

Resident #2, was admitted to the facility 12-6-13. Diagnoses included; femur fracture, dementia, insomnia, hypertension, neuralgia, glaucoma, atrial fibrillation, anemia, anxiety, History of urinary tract infections, and skin cancer.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3-31-16 was coded as a quarterly assessment. Resident #2 was coded as having short and long term memory deficits and required extensive assistance with making daily life decisions. Resident #2 was also coded as needing extensive to total assistance of one staff member to perform activities of daily living. Section M, the area devoted to identification of skin issues, revealed Resident #2 had been coded as at risk for development of pressure ulcers, however, had no pressure ulcers.

Resident #2's nursing progress notes were reviewed and revealed that on 4-29-16 the Resident was identified to have a pressure ulcer on her sacrum, and that treatment was initiated. No other notes describe the wound until a full assessment note was completed on 5-2-16 by Registered Nurse (RN) C. A skin assessment was conducted on 4-29-16 and documented on a second form as a stage 3 pressure ulcer upon

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identification. Those forms are described and included in detail below.

Review of Resident #2's clinical record revealed 2 facility documents both named "Initial Skin Documentation/Assessment Form." The forms documented that on 4-29-16, Resident #2 had developed, and been identified with a Stage III pressure ulcer, to the coccyx. This was the initial identification and evaluation. The document stated that the wound measured 1.2 centimeters (cm) long by 1.0 cm wide by 0.2 cm deep, had purulent (pus) drainage, had 55% granulation tissue (healing), and 45% intact purple skin, and the surrounding tissue was bright red.

The most recent Guidance from NPUAP (National Pressure Ulcer Advisor Panel) April 2016, defined staging of pressure ulcers as follows:

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Stage 3 Pressure Injury: Full-thickness skin loss

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Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

The facility skin assessments (3 total) continued weekly from initial identification and continuing for 2 more weeks up until the time of survey, were reviewed and were as follows:

1. The initial assessment was documented on

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4-29-16. For this assessment the wound was described as "measurements of 1.2 centimeters (cm) long by 1.0 cm wide by 0.2 cm deep, had purulent (pus) drainage, had 55% granulation tissue (healing), and 45% intact purple skin, pain was not documented, and the surrounding tissue was bright red."

2. The second facility assessment was documented on 5-5-16. For this assessment the wound had progressed to reveal measurements of "0.9 cm long x 0.5 cm wide x 0.2 cm deep, had serosanguinous drainage (clear/bloody), had Granulation tissue 60% and yellow necrotic slough 40%, with episodic pain, and surrounding tissue was bright red.

3. The third facility assessment was documented on 5-12-16. For this assessment the wound had improved to reveal measurements of "0.6 cm long x 0.2 cm wide x 0. 1 cm deep, had serosanguinous drainage (clear/bloody), had Granulation tissue 100%, with episodic pain, and surrounding tissue was bright red.

Resident #2 was observed by surveyors on 5-18-16, at 3:00 p.m. during wound care observations with the Wound nurse Licensed Practical Nurse (LPN) B, and the Assistant Director of Nursing (ADON) Registered Nurse (RN) C. This was the fourth facility assessment, and Resident #2 was lying in bed on her right side exposing the coccyx wound. The wound size had worsened, and measured 0.9 centimeters (cm) long by 0.4 cm wide by 0.1 cm deep. The wound appeared to be healing at the base of wound, and was clean without drainage, pink, moist and had no slough or eschar was present in the wound bed.

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Physician's orders, the Medication Administration Record (MAR), and Treatment Administration Record (TAR), for April and May 2016 were reviewed and revealed the following:

April 2016 - Prior to identifying the stage 3 pressure ulcer on 4-29-16, no preventative skin interventions were ordered. There was an order for Hi Cal supplement 2 ounces twice daily for weight loss 12-23-15, and Promod supplement fruit punch 30 ml (milliliters) for hypoalbuminemia, and weight loss one time per day ordered 2-10-16.

May 2016 - After identifying the stage 3 pressure ulcer, and on 4-29-16, orders appeared on the May most recent recapitulated physician's order sheet/form (POS) for; one Multivitamin tablet every day, one Vitamin C tablet every day for 30 days, one Zinc sulfate capsule every day for 14 days, Juven Orange supplement twice per day for 90 days. The Hi Cal supplement 2 ounces twice daily was increased to three times daily, and the Promod supplement was increased from one time daily to two times daily. There appeared a wound treatment order also on 4-29-16 for "Triad 12's paste", "Cleanse coccyx area with normal saline, pat dry and apply Triad to area, cover with Allevyn dressing daily and as needed until healed, then discontinue. The order was changed on 5/3/16.

On 5-3-16 (5 days after identification) new orders appeared on the POS for Wound Specialist doctors (VOHRA) to evaluate and treat the wound, and for an alternating air mattress.

On 5-5-16 the Wound doctor (VOHRA) initial

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evaluation was completed. The document described the wound as "stage 3, measuring 0.9 cm long x 0.5 cm wide x 0.2 cm deep, had serosanguinous drainage (clear/bloody), had Granulation tissue 60% and yellow necrotic slough 40%, with episodic pain. The doctor recommended to discontinue house barrier cream once daily, and to institute Santyl debridement enzymatic ointment and cover with mepilex dressing, once daily, and as needed. This new order was instituted on 5-6-16, and then discontinued on 5-12-16.

Santyl Ointment is described as; www.santyl.com indicated: "Collagenase SANTYL® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation by Clostridium histolyticum. It possesses the unique ability to digest collagen in necrotic tissue."

On 5-12-16 the Wound doctor (VOHRA) conducted a second evaluation of the wound. The second document described the wound as "stage 3, measuring 0.6 cm long x 0.2 cm wide x 0.1 cm deep, had serosanguinous drainage (clear/bloody), had Granulation tissue 100%. The doctor recommended to discontinue Santyl ointment daily, and to institute Calcium Alginate once daily.

On 5-12-16 a new doctors order was received for Calcium Alginate and cover with mepilex dressing once daily, and as needed. The order included cleaning the wound prior to applying the dressing with normal saline. Calcium alginate dressings are highly absorbent biodegradable dressings

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made from seaweed, and this dressing continued through the time of survey.

Review of Resident #2's skin and pressure ulcer care plan revealed no initiation or revision dates, therefore it is impossible to determine by staff or surveyors if the care plan was instituted before or after the identified pressure ulcer. Under the heading "Problems" The document states "(name of Resident)" has a pressure area", and "Resident has altered skin integrity". The interventions that follow the problem area appear to have been implemented after the identification of the stage 3 pressure ulcer, and not before as a prevention. Evidence concludes that this is the only pressure ulcer wound this Resident had experienced in at least 6 months. This conclusion is born out by 2 previous MDS assessments, which denote that the Resident had no wounds, and MDS assessments were completed every 3 months. The care plan is revised accordingly, quarterly, as the MDS assessment provides the basis for care planning per regulation.

INTERVIEWS;
On 5-18-16, and 5-19-16 interviews were conducted with staff members responsible for the daily care of Resident #2. On 5-19-16 CNA (certified nursing assistant) A, the staff member caring for Resident #2, stated that she had cared for Resident #2, and that she would report to the nurse if there was ever anything different or "not normal". CNA A stated she would report anything different to the nurse as "you never know if the previous person did not report it (a change in the skin)."

When interviewed, during wound care

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observations on 5-18-16, the Certified Wound Care Nurse LPN B, and the nurse providing wound care, the ADON (assistant director of nursing) RN C, indicated that at the time of Resident #2's development of a stage 3 pressure ulcer, the facility did not have a dedicated wound care nurse. The ADON stated that she was present upon identification, and was responsible for identifying, assessing, staging, and measuring Resident #2's stage 3 pressure ulcer. LPN B, and the ADON RN C also stated all of the staff were responsible for reporting any changes in skin integrity to the floor nurse. The floor nurse was to report to a supervisory nurse who would initiate documentation in the nurses notes, and do the initial skin assessment. Then appropriate treatment needs and interventions would be called in to the physician, to obtain an order for. The floor nurses were also responsible for doing a head to toe weekly skin assessment, noting any changes in skin condition, and documenting such.

Review of the facility's policy entitled "Pressure Ulcer Treatment Program" included;

"Procedure:"
All staff were responsible for reporting any changes in skin integrity to the floor nurse. The floor nurse was to report to a supervisory nurse who would initiate documentation in the nurses notes, and do the initial skin assessment. Then appropriate treatment needs and interventions would be called in to the physician, to obtain an order.

"Potential contributing factors should be identified and appropriate preventative strategies should be initiated and documented in the plan of care."

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The document did not state who was responsible for this step.

"The Resident should be discussed at the next care plan meeting where multi-disciplinary approaches can be included in the plan of care." This step in the process could take up to 3 months as care plan meetings are held quarterly.

The facility pressure ulcer policy followed the old NPUAP staging guidelines.

The Administrator, DON, Corporate Vice President of Operations, and RN Corporate Director of Operations were informed of the failure of the staff, for Resident #2, to identify a pressure ulcer before it was identified as a Stage 3 pressure ulcer. The corporate Director of Operations RN consultant stated that staff had identified the deficient practice, and a plan of correction had been developed prior to survey. She was able to provide documentation to that effect, and the following describes the credible evidence for a decision of Past non-Compliance.

On 5-19-16 at 11:00 a.m. the Director of nursing and Administrator presented the facility plan of correction for the incident, which had been previously developed, and after the incident occurred, to prevent further incidents of this nature to occur. The plan of correction included a head to toe assessment of Resident #2, and all residents in the facility. It also included a 100% clinical record audit for all Residents to look for documents that had not been coded correctly, care plans were updated, and risk protocols instituted. The staff was retrained on pressure area identification, and evaluation. Audits are being completed weekly for 6 weeks to include 20

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F 314	Continued From page 10 % of the Residents each week, and reviewed by the DON. The quality Assurance Committee are reviewing these records quarterly, and no new incidents of this type have occurred since this late identification for Resident #2. The facility Allegation of Compliance (AOC) date was 5-13-16, and credible evidence was accepted for the AOC date. This incident is found to be Past Non-Compliance, as the facility identified the non-compliant practice and corrected it prior to survey. The DON and Administrator were notified of the findings at end of day debrief on 5-19-16 at 2:00 p.m. No further information was provided.	F 314		
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 by: Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to provide a hazard free environment for one resident (Resident # 1) in a survey sample of 20 residents. 1. For Resident #1, the facility staff failed to provide a hazard free environment as three	F 323	1. Resident #1's room has been checked for medications at bedside without a physician order. Resident was assessed without negative outcomes. Resident and staff have been reeducated on protocol for medications at bedside. 2. All residents' rooms were checked to ensure there were no medications at the bedside without an order for self-administration. Findings were reviewed to ensure a safe environment for all residents. RNs and LPNs will be responsible for monitoring rooms on an ongoing basis to ensure medications are not left at bedside without appropriate orders and direction.	6/24/16 6/24/16 and ongoing

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F 323	Continued From page 11 bottles of nasal spray were found on the bedside table. Findings included: 1. For Resident # 1, the facility staff failed to provide a hazard free environment as three bottles of nasal spray were found on the bedside table. Resident # 1 was a 72 year old male admitted to the facility on 4/4/2016 with diagnoses of but not limited to: Cardiovascular Accident (stroke) with left sided weakness, Diabetes, History of sustained Ventricular Tachycardia, Metabolic Syndrome, History of Prostate Cancer, Chronic Gout, Allergy, Acute Upper Respiratory Infection, Obstructive Sleep Apnea and Hypertension. The most recent Minimum Data Set (MDS) was an initial assessment with an Assessment Reference Date (ARD) of 5/2/2016. The MDS coded Resident # 1 with BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident #1 was coded as needing limited to extensive assistance of one to two staff members to perform his activities of daily living with the exception of eating. For eating, Resident # 1 was coded as requiring supervision and set up help only. Resident # 1 was coded as being able to hear, speak, understand, and be understood. Resident # 1 was a retired ENT (Ear, Nose and Throat) Physician. On 5/17/2016 at 2:20 PM, during the initial tour of the Colonial unit in the facility with RN B, three bottles of nasal spray were observed on the	F 323	3. The Nursing Education and Training Coordinator/Designee will reeducate RNs, LPNs, and CNAs on "Medications At Bedside". This inservice will include a review of the Medication Administration Guidelines and Pharmacy Services policies. It will also include the importance of notifying the nurse of any medications at bedside, the protocol for determining the residents' ability to self-administer medications as well as how medications should be secured if a resident has an order to self-administer. 4. The Assistant Director of Nursing/Designee will audit 20% of residents' rooms weekly for six weeks to ensure a hazard free environment. The Director of Nursing will review the audit results and will report any trends or variances to the Continuous Quality Improvement Committee on at least a quarterly basis.	6/24/16 and ongoing 6/24/16 and ongoing

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bedside table of Resident # 1. The bottles were not labeled from the facility Pharmacy. The bottles of nasal spray on the bedside table were:

Equaline Oxymetazoline 0.05 % (nasal decongestant) 12 hour relief 1 ounce bottle, Expiration 8/ 2018
Afrin 12 hour Pump Mist extra Moisturizing nasal Spray, 2/3 ounce bottle, Expiration 8/2017
Ipratropium Bromide Nasal Solution 0.06% 15 milliliter bottle, Expiration 10/2017

An interview was conducted immediately with Resident # 1 who stated those were his bottles of medicine. Resident # 1 stated he brought those bottles of medicine into the facility. Resident # 1 stated "I am a physician and knew they would help with my nasal congestion. I am an ENT. One is a saline spray, then there is Afrin and the other is a steroid nasal spray."

RN (Registered Nurse) B who was making rounds with the surveyor stated she had not seen the bottles of nasal spray on the bedside table before the tour. RN B stated "he's a doctor and knows what the medications are used for." The surveyor asked if residents were allowed to have medications by the bedside. RN B stated medications were not allowed at the bedside. RN B stated Resident # 1 had not been assessed for self administration and did not have a Physicians Order to self administer medications.

Review of the clinical record was conducted on 5/17/2016.

Review of the May 2016 Physicians Order Sheet revealed an order for Oxymetazoline HCL(Hydrochloride) Extra Moisturizing 0.05% (1

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spray), non-aerosol (ml)(milliliter) intranasal both nostrils as needed every 12 hours starting 4/4/2016. There were no noted orders for any other nasal sprays.

Review of the May 2016 MAR (Medication Administration Record) revealed the medication Oxymetazoline HCL Extra Moisturizing 0.05% (1 spray), non-aerosol (ml)(milliliter) intranasal both nostrils as needed every 12 hours listed with no documentation of administration during the month of May 2016.

On 5/18/2016 at 8:15 AM, Resident # 1 was observed lying in bed, stating he did not feel well. No medications were noted on the bedside table. Resident # 1 stated "I feel miserable. I have tracheitis and bronchitis."

On 5/18/2016 at 8:55 AM, an interview was conducted with the Corporate Nurse/Acting Director of Nursing (Admin B) who stated she had been informed by RN B that bottles of nasal spray were found on Resident # 1's bedside table during tour. Admin B stated RN B reported she had not seen the medications on the bedside table previously.
Admin B stated the bottles of nasal spray were removed and the staff had informed Resident # 1 why medications could not be kept at the bedside. Admin B stated the Medical Director "gave an order for the Afrin nasal spray and the steroid nasal spray and the other bottle was a saline spray." Admin B stated all medications should be ordered by a resident's physician and should not be kept at the bedside unless the resident had been assessed for self administration and authorized by the physician. Admin B stated there were specific procedures

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after a resident was approved for self administration.

5/18/2016 at 9:10 AM, an interview was conducted with RN B who stated she removed the bottles of nasal spray after explaining the facility policy. RN B stated Resident # 1 willingly gave the medications to the staff and stated Resident # 1 understood why.

5/18/2016 at 9:40 AM, an interview was conducted with the Medical Director (Admin D) who was in the facility making rounds and was the physician for Resident # 1. The Medical Director stated he had been informed about the bottles of nasal spray at the bedside. The Medial Director stated he also explained to Resident # 1 that medications could not be kept at the bedside and that orders had to be written for medications in the facility. The Medical Director stated the facility preserved the option of Residents keeping medications at the bedside for self administration to a minimum due to safety hazards and other residents potentially wandering in the rooms. The Medical Director stated self administration of medications would require a locked box and other controls. The Medical Director stated Resident # 1 was "fine with keeping the medications at the nurses station and requesting them as needed or when scheduled."

During the end of day debriefing on 5/18/2016 at approximately 5:10 PM, the administrator and Corporate consultants were informed that three bottles of nasal spray were found on the bedside table of Resident # 1. At 5:15 PM, Corporate Nurse (Admin C) stated the expectation was that medications were not to be kept at the bedside. Admin C also stated "residents have to have an

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assessment to determine if they can self administer. If they are approved to self administer, we would provide a lock box to keep the medications contained."

On 5/19/2016 at 8:15 AM, observed the resident lying in bed, stating he felt a little better than the day before. No medications were noted at the bedside. Resident # 1 stated his medications were taken by the staff and that he now understood why but had not thought about the impact on others previously. Resident # 1 stated the staff explained the process for having medications at the bedside but he didn't "really know how a lock box and key system would work." Resident # 1 stated he was fine to leave the medicines at the nurses station but had been curious to know if he would be in control of the key if the medications were kept at the bedside. Resident # 1 stated he understood that the facility needed to have rules for the safety of everyone and was appreciative of the efforts of the staff to protect everyone.

On 5/19/2016 at 1:20 PM, Admin B presented a copy of the Physician Order Sheet with new orders written on 5/18/2016 at 9:57 AM for two nasal sprays. The orders were for: Oxymetazoline HCL Extra moisturizing 0.05% (2 sprays) intranasal one time daily at bedtime and Ipratropium Bromide 0.06% (2 spray) aerosol intranasal one time daily.

On 5/19/2016 at approximately 2:15 PM, Admin C presented a copy of the Facility Medication Administration Policy and stated it "did not specifically discuss medications at the bedside but no medications can be kept at the bedside unless in a lock box after the resident has been

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F 323	Continued From page 16 assessed for self administration." Review of the Facility's Medication Administration Guidelines revealed a statement on Page one of 4 under Medication Administration: "Residents are allowed to self-administer medications when specifically authorized by the attending physician and the interdisciplinary team (IDT) and in accordance with procedures for self-administration of medications." During the end of day debriefing on 5/19/2016 at 2:15 PM, the Administrator, Admin B and Admin C were informed of the findings. No further information was provided.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure a medication error rate of less than 5%. The facility's medication error rate was 8 %. There were two errors in 25 opportunities. Potassium ER and Tylenol Arthritis ER was crushed and then administered to residents. The findings included:	F 332	1. Residents # 10 and #11 were assessed without negative outcomes related to crushed extended release medications . The physician and responsible party were notified of above and new orders were obtained to ensure appropriate administration of medication. The responsible nurses were reeducated on appropriate medication administration techniques in regards to crushing medications. The "do not crush" medication list was reviewed with staff members at this time as well as use of the drug information sheet available on EHR.	6/24/16

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F 332	Continued From page 17 On 5/17/16 and 5/18/16, the medication pass was observed. LPN (licensed practical nurse) A was observed. At 3:45 PM, LPN (A) prepared medications for Resident #10. Potassium 20 meq (milliequivalents) ER (extended release) was crushed. On 5/18/16 at 8:45 AM, Resident #11's medications were prepared. RN (registered nurse) A poured medications including Tylenol Arthritis ER one tablet. RN (A) crushed the medications and administered with pudding. RN (A) was asked to read the order. RN (A) stated , "You do not crush extended release medications. Resident #10, was admitted to the facility 4/8/11. Diagnoses included congestive heart failure, high blood pressure and diabetes. Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/6/16 was coded as a quarterly assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) score of "1 out of a possible 15, or severe cognitive impairment. Resident #10 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility. Resident #10's POS (physician order sheet) dated 5/12/16 was reviewed. The order for Potassium read: "Klor Con 20 meq one tablet, Extended Release, twice daily." On 5/1/16 at at 5:30 PM, LPN (A) stated, "I did not know you can't crush it." Resident #11 was admitted to the facility 4/8/16.	F 332	2. The involved nurses will be observed with medication pass focusing on medications requiring crushing to ensure medications are not inappropriately crushed. The Director of Nursing/Designee reviewed medication list of all residents receiving crushed medications to ensure appropriate formulation of medication is ordered. Medication nurses will be responsible for ensuring medication are administered according to administration instructions to prevent medications from being inappropriately crushed on a daily basis. 3. The Nursing Education and Training Coordinator/Designee will reeducate RNs and LPNs on "Medication Administration". The in-service will include but is not limited to a review of the Medication Administration Policy and the Institute of Safe Medication Practices (ISMP) Oral Dosage Forms (2015) emphasizing long-acting or enteric coated dosage forms not being crushed unless otherwise ordered by a physician. 4. The Nursing Education and Training Coordinator/Designee will perform five medication pass audits per week for six weeks to ensure nurses are following facility policy and manufacturers recommendations for medication administration. The Director of Nursing will review results and report any trends or variances to the Continuous Quality Improvement Committee on at least a quarterly basis.	6/24/16 and ongoing 6/24/16 and ongoing 6/24/16 and ongoing

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F 332	Continued From page 18 Diagnoses included dementia, high blood pressure and high blood pressure. Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/12/16 was coded as a significant change in status assessment. Resident #11 was coded as having a BIMS (brief interview of mental status) score of "1" out of a possible 15, or severe cognitive impairment. Resident #11 was also coded as requiring extensive assistance of two staff members to perform activities of daily living, such as bed mobility. . Resident #11's POS dated 5/12/16 contained the following order: Acetaminophen 8 hour caplet one tab extended release twice daily. Review of the facility's drug book, Mosby's 2015 Nursing Drug Book, page 89 reads as followed, "Do not crush extended release medications." Saunders Nursing Drug Handbook, 2011, page 1275, read as followed, "Medication irritating to the stomach may be enteric coated, delaying release of the medication until it reaches the small intestine." Review of the facility's policy and procedure titled Medication Administration Guidelines contained the following: "Long acting or enteric coated dosage forms should generally not be crushed and require a physician's order to do so." On 5/18/16 at the end of the day meeting, the facility Administrator and DON (director of nursing) were notified of the above findings.	F 332		
F 333	483.25(m)(2) RESIDENTS FREE OF	F 333		

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F 333 SS=D	Continued From page 19 SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to ensure one resident, Resident #10 was free from significant medication error, in a survey sample of 19 residents. Resident #10's extended release potassium was crushed. The findings included: On 5/17/16 and 5/18/16, the medication pass was observed. LPN (licensed practical nurse) A was observed. At 3:45 PM, LPN (A) prepared medications for Resident #10. Potassium 20 meq (milliequivalents) ER (extended release) was crushed. Resident #10, was admitted to the facility 4/8/11. Diagnoses included congestive heart failure, high blood pressure and diabetes. Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/6/16 was coded as a quarterly assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) score of "1 out of a possible 15, or severe cognitive impairment. Resident #10 was also coded as requiring extensive assistance of one staff member to	F 333	1. Resident #10's medication orders were reviewed with the physician and new orders were received for liquid form of medication. The Responsible Party was made aware of changes and medication error. The nurse involved was reeducated on medications that should not be crushed and use of the medication instruction available on EHR. 2. The Director of Nursing/Designee reviewed all residents' medication orders to identify any medications that should not be crushed. A medication pass observation was performed on both nurses who crushed extended release medications to ensure there are no significant medication errors. The medication nurses will be responsible for ensuring medications that are enteric coated, extended and/or delayed release are not crushed on a daily basis. 3. The Nursing Education and Training Coordinator/Designee will reeducate RNs and LPNs on "Medication Administration Guidelines". The inservice will include a review of the Medication Administration Guidelines policy, use of the medication instructions on the EHR and a review of the Institute of Safe Medication Practices (ISMP) Oral Dosage Forms (2015) emphasizing long-acting or enteric coated dosage forms not being crushed unless otherwise ordered by the physician.	6/24/16 6/24/16 and ongoing 6/24/16 and ongoing

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F 333	Continued From page 20 perform activities of daily living, such as bed mobility. Resident #10's POS (physician order sheet) dated 5/12/16 was reviewed. The order for Potassium read: "Klor Con 20 meq one tablet, Extended Release, twice daily." On 5/1/16 at at 5:30 PM, LPN (A) stated, "I did not know you can't crush it." Review of the facility's drug book, Mosby's 2015 Nursing Drug Book, page 89 read as follows, "Do not crush extended release medications." Review of the facility's policy and procedure titled Medication Administration Guidelines contained the following: "Long acting or enteric coated dosage forms should generally not be crushed and require a physician's order to do so." On 5/18/16 at the end of the day meeting, the facility Administrator and DON (director of nursing) were notified of the above findings.	F 333	4. The Nursing Education and Training Coordinator/Designee will perform five medication pass observations weekly for six weeks to ensure long-acting and enteric coated medications are not crushed. The Director of Nursing will review the audit results for any patterns or trends and report findings to the Continuous Quality Improvement Committee on at least a quarterly basis.	6/24/16 and ongoing