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	495345	A. BUILDING ______ B. WING ______	C 10/12/2017

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LANCASHIRE CONVALESCENT AND REHABILITATION CENTER	**287 SCHOOL STREET KILMARNOCK, VA 22482**

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 10/10/17 through 10/12/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 120 certified bed facility was 70 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 1-13 and 19) and 5 closed record reviews (Residents 14-18).	F 000		
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, facility and clinical record review, the facility failed to ensure, for two residents (Resident #10 and Resident #6) in a survey sample of 19 residents, reasonable accommodation of needs. 1. The facility failed to keep the bariatric lift plugged in and available for use for Resident #10.	F 246	F 246 The dates of completion serve as my allegation of compliance. 1. Resident #6 and #10 have been monitored to ensure the staff provide services to accommodate the individual needs of the residents with focus on	11/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/23/2017

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

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2. The facility staff failed to make sure the bariatric lift was powered and available for use, for Resident #6.

The findings included:

Resident #10 was admitted to the facility after a hospitalization on 8/24/17. Diagnoses included muscular dystrophy, quadriplegia, sleep apnea and neurogenic bowel.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/17 was coded as an admission 14 day assessment. Resident #10 was coded as having no memory deficits and was able to make own daily life decisions. Resident #10 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living such as toileting and hygiene. The resident was coded as being totally incontinent of bowel.

On 10/11/17 at 10:00 AM, a group meeting with the residents on the Resident Council was conducted. Resident #10 voiced during the meeting that the large (bariatric) lift was not always available. He stated, "I had to stay up until 8:00 PM because the staff does not plug in the lift to charge and the batteries go flat."

On 10/11/17 at 2:00 PM, Resident #10 was in the dining room in his wheelchair. Resident #10 was asked what time did he go back to bed in the afternoon. He stated, "I try to get back in bed by 4:00 (PM) because that is when they give me my fluid pill."

On 10/11/17 at 2:15 PM, accompanied by LPN

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ensuring bariatric lifts are charged and available for resident transfers. Staff have been educated on the importance of providing services to accommodate the needs of residents in regards to availability of functioning bariatric lifts for resident transfers.

2. All mechanical lifts have been monitored by the Administrator/Designee to ensure individual needs and/or services have been met including functional bariatric lifts for transfers. The Charge Nurse will be responsible for ensuring residents are receiving services to accommodate their needs on a daily basis by ensuring all mechanical lifts are properly charged and functional for transfer of residents.

3. RNs, LPNs, and CNAs will be in-serviced on Accommodation of Needs. This in-service will include but is not limited to the importance of the resident□s right to receive services in the facility to accommodate their individual needs and the expectation of staff to provide these needs and identify any individual needs in accordance with Resident Rights.

4. The Administrator/Designee will monitor all mechanical lifts on a daily basis for six weeks to ensure that they are available to meet resident needs. The Administrator/Designee will report any trends or patterns to the Quality Assessment and Assurance Committee at least quarterly.

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(G), the bariatric lift was observed stored in the classroom of the facility. The lift was not plugged in. When the battery level was checked, it was at half power level.

On 10/11/17 at the end of the day meeting, the handbook for the bariatric lift was presented. Under "Charging the Batteries", the booklet documented: "Ensure the battery box power switch is on. Insert the charger plug into the battery box charging socket. Insert the other charger plug into the power supply."

On 10/12/17 at 9:45 AM, an interview was conducted with CNA (certified nursing assistant) B. She stated, "The batteries definitely go dead. Some of the aides don't plug them up."

On 10/12/17 at approximately 12:00 PM, the Administrator and DON were informed of the above findings

2. For Resident # 6, the facility staff failed to make sure the bariatric lift was powered and available for use.

Resident #6 was originally admitted to the facility on 3/3/2017, readmitted on 7/26/17 and again readmitted 8/11/2017 with the diagnoses of, but not limited to, Diabetes, Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease, Central Cord Syndrome C1-C4, Neurogenic Bladder with Foley Catheter, Neurogenic Bowel, Urethritis, Psychotic Disorder with Hallucinations, Seizure Disease and Morbid Obesity.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an

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Assessment Reference Date (ARD) of 8/18/17. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 6 was coded as requiring extensive to total assistance of one to staff person for Activities of Daily Living; required set up only for eating and hygiene; and was coded as always incontinent of bowel and had an indwelling catheter for the bladder.

On 10/10/17 at 2 p.m., Resident # 6's clinical record was reviewed. The review of the MDS and clinical record revealed Resident # 6 required total assistance of two staff persons for transferring, toileting and bathing. The clinical record revealed the facility staff used a bariatric lift to transfer Resident # 6.

On 10/11/2017 at 8:40 a.m., an interview was conducted with Resident # 6 who stated the bariatric lift is often not available because the battery is not charged. She stated she told the staff they can leave it in her room since she has a big room with an outlet by the door. Resident # 6 said she has to wait sometimes to go outside for a smoke break or go to an activity because the battery is not charged.

On 10/11/2017 at 2:00 p.m., Resident # 6 was observed outside smoking with Certified Nursing Assistant D observing her. Resident # 6 stated she liked to go outside to smoke sometimes during the day and was glad to be able to go outside that day.

During the end of day debriefing on 10/11/2017, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings.

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F 246	Continued From page 4 No further information was provided.	F 246		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		11/13/17

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material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to complete an accurate MDS (Minimum Data Set)/RAI (Resident Assessment Instrument) assessment for 1 resident (Resident #7) of 19 residents in the survey sample.

The facility staff failed to include appropriate Resident diagnoses on MDS report of 7/3/2017 for Resident #7.

Findings included:

Resident #7, an 85-year-old female, was admitted to the facility on 11/19/2010 and readmitted on 2/2/2011. Her diagnoses included aphasia, delusional disorder, hypertension, unspecified mental disorder, malnutrition, dementia, reflux, psychotic disorder, and anxiety.

Resident #7's most recent MDS with an ARD (Assessment Reference Date) of 7/3/2017 was coded as a quarterly assessment. She was assessed as having moderate cognitive impairment by staff assessment. Resident #7 was coded as needing extensive assistance of one person for her activities of daily living and as being always incontinent of bowel and bladder.

A clinical record review was conducted on 10/17/2017 at 1:45 PM. It revealed an MDS document with an ARD of 7/3/2017. Section I, "Active Diagnoses" listed hypertension and malnutrition as the only diagnoses for Resident #7. Missing diagnoses were aphasia, delusional disorder, unspecified mental disorder, dementia,

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The dates of completion serve as my allegation of compliance.

1. Resident # 7□s MDS with an ARD of 7/3/17 was updated to reflect the diagnoses of aphasia, delusional disorder, unspecified mental disorder, dementia, reflux, psychotic disorder, and anxiety.
2. The Resident Assessment Coordinator/Designee will review the MDS of current residents completed in the past 30 days to ensure complete documentation in Section I regarding diagnoses.
3. Facility MDS team members will be reeducated regarding completion of Section I: Active Diagnoses. The in-service will include but is not limited to a review of the Resident Assessment Instrument (RAI) guidelines for documentation.
4. The Assistant Director of Nursing/Designee will review 20% of MDS□s completed weekly for six weeks to ensure accuracy of Section I. Any trends or patterns will be reported to the Quality Assessment and Assurance Committee at least quarterly.

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F 278	Continued From page 6 reflux, psychotic disorder, and anxiety. On 10/12/2017 at 10:20 AM an interview was conducted with LPN (Licensed Practical Nurse) F, MDS Coordinator. She stated that, in the preparation of this MDS report, Resident #7's diagnoses were incorrectly not completed. Administration was informed of the findings on 10/12/2017 at 11:55 AM.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		11/13/17

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(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

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

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

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

(A) The attending physician.

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

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

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

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

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medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan.

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

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview, facility documentation and clinical record review, the facility failed for one resident (Resident #10) in a survey sample of 19 residents, to review and revise the care plan.

Resident #10's care plan was not revised to reflect recurrent bouts of constipation.

The findings included:

Resident #10 was admitted to the facility after a hospitalization on 8/24/17. Diagnoses included muscular dystrophy, quadriplegia, sleep apnea and neurogenic bowel.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/17 was coded as an admission 14 day assessment. Resident #10 was coded as having no memory deficits and was able to make own daily life decisions. Resident #10 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily

F 280

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The dates of completion serve as my allegation of compliance.

1. The care plan for Resident #10 was reviewed to ensure accuracy and reflect the resident□s current needs. The nurses responsible for care planning were reeducated on ensuring resident care plans are updated as needed and are reflective of individual needs and conditions.
2. The Assistant Director of Nursing/Designee will review current resident care plans to ensure constipation is reflected on the care plan if indicated. The Assistance Director of Nursing/Designee will be responsible for ensuring that resident care plans are updated as needed to reflect individual needs and conditions.
3. RNs/LPNs will be reeducated by the Director of Clinical performance/Designee

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living such as toileting and hygiene. The resident was coded as being totally incontinent of bowel.

On 10/11/17 at 10:00 AM, a group meeting with the residents on the Resident Council was conducted. Resident #10 voiced during the meeting that he had been constipated (no BM-bowel movement for five days) and called 9-11 to go to the ER (emergency room) twice since his admission.

Review of the clinical record revealed on 9/5/17 that the resident received a Fleet's enema for no bowel movement for three days. The enema was effective. On 9/15/17, the resident had no BM for three days; the resident called 9-11 and was transferred to the ER on 9/17/17. There a CT scan was done which showed a "mild colonic ileus." Merck manual states an ileus is "a temporary absence of the normal contractile movements of the intestinal wall." The Muscular Dystrophy Association states, "A combination of immobility and weak abdominal muscles can lead to severe constipation". On 10/1/17, Resident #10 received Milk of Magnesia, a Dulcolax suppository and two Dulcolax tablets for no BM for five days with "small" results. Again, the resident called 9-11 to go to the ER.

Review of Resident #10's care plan dated 9/12/17, the resident's care plan was not revised for his constipation issues until 10/3/17.

On 10/12/17 at approximately 12:00 PM, the Administrator and DON (director of nursing) were informed of the above findings.

On 10/12/17 at 12:20 PM, the DON, who completed the care plan stated, "I messed up."

F 280

on Updating Resident Care Plans. The in-service will include but is not limited to a review of facility policy on care plans and the importance of ensuring they are updated timely as necessary to reflect current needs and diagnoses.
4. The Director of Nursing/Designee will review 10% of current resident care plans weekly for six weeks to ensure care plans reflect constipation if indicated and are updated with the change in a timely manner. Any trends or patterns will be reported to the Quality Assessment and Assurance Committee at least quarterly.

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F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		11/13/17

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Based on observation, resident and staff interview and facility documentation, the staff failed for one resident (Resident #10) in a survey sample of 19 residents, to initiate a timely bowel program.

Resident #10 had recurrent bouts of constipation; he was not placed on a scheduled bowel program until 9/25/17.

The findings included:

Resident #10 was admitted to the facility after a hospitalization on 8/24/17. Diagnoses included muscular dystrophy, quadriplegia, sleep apnea and neurogenic bowel.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/17 was coded as an admission 14 day assessment. Resident #10 was coded as having no memory deficits and was able to make own daily life decisions. Resident #10 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living such as toileting and hygiene. The resident was coded as being totally incontinent of bowel.

On 10/11/17 at 10:00 AM, a group meeting with the residents on the Resident Council was conducted. Resident #10 voiced during the meeting that he had been constipated (no BM- bowel movement for five days) and called 9-11 to go to the ER (emergency room) twice since his admission.

Review of the clinical record revealed on 9/5/17 that the resident received a Fleet's enema for no bowel movement for three days. The enema was

F 309

F 309

The dates of completion serve as my allegation of compliance.

1. Resident # 10's medication regimen and bowel elimination pattern was reviewed with no changes. The resident was without negative outcomes related to constipation and was discharged to home on 10/19/17.
2. The Assistant Director of Nursing/Designee has reviewed the bowel movement report for current residents to ensure residents who did not have a bowel movement in three or more days received treatment. The charge nurse will be responsible for reviewing the bowel movement report on a daily basis and ensuring the bowel management protocol has been implemented per physician order.
3. The Director of Clinical Performance/Designee will in-service RNs and LPNs on Providing the Necessary Care and Services. The in-service will include a review of facility policy on bowel management. The in-service will include identifying residents at risk for constipation, implementing preventive measures, and daily monitoring with review of the bowel management protocol.
4. The Director of Nursing/Designee will monitor the bowel movement report daily for six weeks to ensure bowel protocol is initiated as needed. Any variances will be investigated and corrective action initiated. The Director of Nursing/Designee will identify any trends

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F 309	Continued From page 12 effective. The resident had no scheduled laxatives, only prn or as needed. On 9/17/17 at 7:46 AM, the nurse's notes read: "Resident had complaint of constipation with pain. .. abdomen tender to touch. Resident reports concern of having blocked bowels as this caused the death of a close relative. ... resident given an enema on previous shift and reports no relief. Dulcolax suppository given and two Tylenol for pain." According to 9/17/17 nurse's notes at 4:30 PM, the resident complained of "bilateral lower quadrant abdominal pain. Bowel sounds hypoactive in all four quadrants. Abdomen obese and tender." On 9/17/17, the resident had no BM for three days; the resident called 9-11 and was transferred to the ER at 4:30 PM. In the ER a CT scan was done which showed a "mild colonic ileus." Merck manual states an ileus is "a temporary absence of the normal contractile movements of the intestinal wall. The Muscular Dystrophy Association states, "A combination of immobility and weak abdominal muscles can lead to severe constipation". Magnesium Citrate was given in the ER and the resident had a large liquid stool. On 9/18/17, the NP (nurse practitioner) notes read: "Discussed bowel program... MOM (milk of magnesia), Dulcolax prn (as needed)." It wasn't until 9/25/17 that the resident was placed on scheduled laxatives including: Dulcolax 5 mg (milligrams) tablet once daily and Miralax 17 grams once daily. On 10/1/17, Resident #10 received Milk of Magnesia, a Dulcolax suppository and two Dulcolax tablets for no BM for five days with	F 309	and patterns and report findings to the Quality Assessment and Assurance Committee at least quarterly.	

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F 309	Continued From page 13	F 309		

"small" results. Again, the resident called 9-11 to go to the ER.

On 10/11/17 at approximately 3:00 PM, Resident #10 stated, "I called 9-11 the second time I went to the ER (10/2/17) because the NP told me the medicine (Citrate of Magnesium) would not be available until 11:00 that night."

Review of the NP notes dated 10/2/17 revealed: "Offered Dulcolax 4 tabs or Lactulose- refused: " Mag Citrate to be delivered tonight." Review of the pharmacy receipt dated 10/2/17 indicated the Magnesium Citrate arrived at 10:50 PM.

Review of Resident #10's care plan dated 9/12/17, the resident's care plan was not revised for his constipation issues until 10/3/17.

Review of the facility's policy regarding BM Management Program revealed:

* Review medical record and interview resident if possible
* Review bowel incontinence record
*Toilet resident according to plan of care
* Determine adequate fluid intake levels and plan of offering
* Print BM list daily for residents with no BM for three days
* Administer laxatives/enemas as per physician orders
* Assess for needed changes in the following: Dietary, Medications, scheduled toileting

On 10/2/17 at 11:30 AM, an interview with the DON (director of nursing) was conducted . The DON stated, "I and the charge nurses review the BM records." She went on to state that the

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F 309	Continued From page 14 record was reviewed daily. She stated, "We were supposed to start laxatives on 9/30/17." On 10/12/17 at approximately 12:00 PM, the Administrator and DON were informed of the above findings.	F 309		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility documentation and clinical record review, the facility staff failed to ensure medication was available for Resident #10, in a survey sample of 19 residents. Resident #10's Citrate of Magnesium was not available for use. The facility did not notify the backup pharmacy that the medication was needed and the medication did not arrive until six hours later. The findings included:	F 425	F 425 The dates of completion serve as my allegation of compliance. 1. Resident #10□s medical record was reviewed to ensure all medications were available and received from pharmacy timely, and administered as ordered without any variances. There were no negative effects related to unavailable medications and the resident was discharged to home on 10/19/17. 2. The Director of Nursing/Designee has checked the supply of all current	11/13/17

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Resident #10 was admitted to the facility after a hospitalization on 8/24/17. Diagnoses included muscular dystrophy, quadriplegia, sleep apnea and neurogenic bowel.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/17 was coded as an admission 14 day assessment. Resident #10 was coded as having no memory deficits and was able to make own daily life decisions. Resident #10 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living such as toileting and hygiene. The resident was coded as being totally incontinent of bowel.

On 10/1/17, Resident #10 received Milk of Magnesia, a Dulcolax suppository and two Dulcolax tablets for no BM for five days with "small" results. Again, on 10/2/17, the resident called 9-11 to go to the ER.

On 10/11/17 at approximately 3:00 PM, Resident #10 stated, "I called 9-11 the second time I went to the ER (10/2/17) because the NP told me the medicine (Citrate of Magnesium) would not be available until 11:00 that night." Resident #10 had stated earlier that the Magnesium Citrate had helped before.

Review of the NP notes dated 10/2/17 revealed: "Offered Dulcolax 4 tabs or Lactulose- refused: " Mag Citrate to be delivered tonight." Review of the pharmacy receipt dated 10/2/17 indicated the Magnesium Citrate arrived at 10:50 PM.

On 10/12/17 at 11:30 AM, there was no documentation that the back-up pharmacy was notified. The DON (director of nursing) stated,

residents medications to be sure medications were all available, received and administered timely, and to identify pharmacy and provider were notified of any variances with new orders or further directions obtained as indicated. The Charge Nurse will be responsible for ensuring all new orders are checked to ensure medications are available timely and administered as ordered.

3. The Nursing Education and Training Coordinator/Designee will in-service RNs and LPNs on Pharmaceutical Service Accurate Procedures. The in-service will include a review of pharmacy policy on Medication Shortages and Unavailable Medications. This in-service will also include but is not limited to procedure to assure pharmacy is notified when a medication is not available, and contacting after hours on call pharmacy for emergency delivery, use of an emergency (back-up) third party pharmacy, and notifying provider to obtain further orders or directions to ensure medications are received, and administered to meet the needs of each resident.

4. The Director of Nursing/Designee will audit 10% of current residents medication supplies weekly for six weeks to ensure medications are available for administration. Any variances will be investigated. The Director of Nursing/Designee will report any trends to the Quality Assessment and Assurance Committee at least quarterly.

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F 425	Continued From page 16 "He refused to wait." The DON could not provide documentation of this event. On 10/12/17 at approximately 12:00 PM, the Administrator and DON were informed of the above findings. COMPLAINT DEFICIENCY	F 425		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		11/13/17

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F 441	Continued From page 17 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to	F 441	F 441	

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F 441	Continued From page 18 implement an effective infection control program. The facility staff failed to assure that fingernails were cut to a short length on three direct care staff. The Findings included: The following three direct care staff was observed with long fingernails: LPN B was observed to have broken and chipped long artificial multicolored nails approximately 1/4" in length during medication administration on 10/10/17 at 4:00 P.M. LPN E was observed to have a few long natural unpolished nails approximately 1/4" in length, and a few chipped nails during medication pass on 10/11/17 at 8:15 AM. LPN A was observed to have long artificial nails approximately ½" in length during on 10/10/17 at 4:00 P.M. On 10/11/17 at 11:00 A.M., an interview was conducted with the Infection Control Nurse (RN A). When asked about the facility's expectation regarding the length of fingernails, she stated that the facility goes by the Center for Disease Control's (CDC) recommendations. She further stated that she didn't have the recommendations at the facility, but would obtain a copy. On 10/11/17 at 3:15 P.M. an interview was conducted with LPN A, whose fingernails were 1/2 inch long, with a black substance underneath. When asked if the facility would be in agreement	F 441	The dates of completion serve as my allegation of compliance. 1. The fingernails of LPN B, LPN E, and LPN A were inspected and found to be neat, clean, and trimmed to a length of one quarter of an inch or shorter. Theses nurses were reeducated on the Nursing Uniform and Appearance Policy. 2. The Director of Nursing / Designee observed all direct care staff to ensure hand hygiene procedures were followed by staff involved in direct resident contact, to include length and hygiene of fingernails. 3. RNs, LPNs, and CNAs will be reeducated by the Director of Clinical Performance/Designee on Infection Control: Fingernails. The in-service will include but not be limited a review of the Nursing Uniform and Appearance Policy and ensuring fingernails are neat, clean, and trimmed to one quarter of an inch or less to reduce the transmission of microorganisms. 4. The Director of Nursing/Designee will inspect five random staff members weekly for six weeks to ensure nails are in a condition that is compliant with facility policy and infection control standards for long term care. The Director of Nursing/Designee will report any trends to the Quality Assessment and Assurance Committee at least quarterly.	

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with her nails being in that condition she stated, "The facility probably would not be ok with it."

On 10/12/17 at 10:00 A.M. the Director of Nursing (DON- Administration B) was interviewed. The DON stated, "After you talked to me yesterday, I checked her nails (LPN A), they were not an acceptable length."

On 10/12/17 a review was conducted of facility documentation, revealing the Nursing Uniform and Appearance Policy, I dated 12/14/13. It read, "Fingernails must be clean, neat and trimmed to one quarter of an inch or less to reduce transmission of microorganisms."

Guidance was given at www.cdc.gov, "Whether artificial nails contribute to transmission of health-care-associated infections is unknown. However, HCWs (Health Care Workers) who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing (347--349). Whether the length of natural or artificial nails is a substantial risk factor is unknown, because the majority of bacterial growth occurs along the proximal 1 mm of the nail adjacent to subungual skin (345,347,348). Recently, an outbreak of P. aeruginosa in a neonatal intensive care unit was attributed to two nurses (one with long natural nails and one with long artificial nails) who carried the implicated strains of Pseudomonas spp. on their hands (350). Patients were substantially more likely than controls to have been cared for by the two nurses during the exposure period, indicating that colonization of long or artificial nails with Pseudomonas may have contributed to causing the outbreak. Personnel wearing artificial

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F 441	Continued From page 20 nails also have been epidemiologically implicated in several other outbreaks of infection caused by gram-negative bacilli and yeast (351--353). Although these studies provide evidence that wearing artificial nails poses an infection hazard, additional studies are warranted." The facility Administrator (Administration A) was informed of the findings on 10/12/17 at 11:00 A.M. No further information was received.	F 441		
F 518 SS=D	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure that staff was adequately trained on emergency preparedness procedures. A nursing staff member was unable to describe procedures to use in case of a fire in a resident's room. Findings included: On 10/11/2017 at 3:15 PM CNA (Certified Nursing Assistant) A, Nursing Assistant was questioned on disaster and emergency preparedness procedures to determine basic knowledge. She was unable to properly describe actions to take if discovering a fire in a resident's room	F 518	F 518 The dates of completion serve as my allegation of compliance. 1. CNA A was reeducated on actions to take if a fire is discovered in a resident room, fire safety acronyms such as RACE, locations of fire alarms and extinguishers, and the use of a fire extinguisher. 2. Facility employees will be educated on emergency preparedness upon hire and at least annually. Drills will be conducted at least quarterly per shift to ensure that staff demonstrate proper knowledge and promote resident safety. 3. Facility staff will be reeducated by the	11/13/17

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F 518	Continued From page 21 (RACE=Rescue, Alarm, Contain, Extinguish). She also did not know the locations of fire alarms and fire extinguishers, and the use of a fire extinguisher. On 10/12/2017 at 10:30 AM an interview was conducted with Administration C, Corporate Nurse Consultant. She produced documents that showed that CNA A had received fire safety training on 9/5/2017. She did not know why CNA A was unable to answer questions on this subject. Administration was informed of findings on 10/12/2017 at 11:55 AM.	F 518	Director of Clinical Performance/Designee on Emergency Preparedness. The in-service will include but is not limited to responding to a fire emergency, the use and location of fire extinguishers and pull stations, and review of the acronyms. 4. The Administrator/Designee will review the in-service records at least quarterly to ensure that facility staff is receiving adequate education regarding emergency preparedness and fire safety. The Administrator/Designee will report any identified trends to the Quality Assessment and Assurance Committee at least quarterly.	