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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/6/17 through 6/8/17. Complaints were investigated during the survey. 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 190 certified bed facility was 163 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #1 through #22) and six closed record reviews (Residents #23 through #28).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		7/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/30/2017

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician and/or RP (responsible party) of treatments and medications not administered or available for administration, for three of 28 residents in the survey sample, Resident #15, #3 and #22. 1. The facility staff failed to notify the physician and RP when Resident #15 refused her breathing treatments 37 times in May 2017.	F 157	F157 Notification of Changes, Injuries, Decline, Room change, Roommate assignments changed, discharges, transfers, and meds not available, meds refused. 1) Notification occurred for: a. The physician and RP was notified for Resident # 15 regarding the refusal of scheduled nebulizer treatments. Orders were received to discontinue the treatment 06/07/17. b. The physician and RP was notified	

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F 157	Continued From page 2 2. The facility staff failed to notify the physician that a medication prescribed for Resident #3 was not available on 10/10/16 and 12/27/16. 3. The facility staff failed to make the physician aware medications were not administered to Resident #22 on 5/25/17. The findings include: 1. The facility staff failed to notify the physician and RP when Resident #15 refused her breathing treatments 37 times in May 2017. Resident #15 was admitted to the facility on 11/10/10 with diagnoses that included but were not limited to; bronchitis (a respiratory condition affecting breathing), osteoarthritis (a type of arthritis affecting tissue at the end of the bones), dementia, and high blood pressure. Resident #15's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 4/10/17. Resident #15 was coded as scoring six out of a possible 15 in Section C, Cognitive Patterns, BIMS (brief interview for mental status), indicating that Resident #15 is severely cognitively impaired with daily decision making. A review of Resident #15's "Physician Order Report" dated 5/1/2017 - 5/31/2017 revealed, in part, the following physician order: "Order Type: Prescription. Start Date: 4/28/2017. End Date: Open Ended. Description: Ipratropium - albuterol solution [a breathing treatment, solution (1)] for nebulization [A nebulizer is a small machine that turns liquid medicine into a mist (2)], 0.5 mg	F 157	that Resident #3 did not receive his eye drops on two occasions on 06/07/17. No new orders were received. c. The physician and RP was notified on 06/07/17 that Resident #22 was not administered Atorvastatin as ordered. No new orders were received. 2) All residents have the potential to be affected by the same practice. a. Medication Administration compliance report will be run each shift to ensure all medications were administered as ordered. b. Medication Administration compliance reports will be reviewed in morning clinical meeting each day to ensure medications were administered as ordered. 3) Licensed nurses will be in-serviced by Director of Nursing or designee: a. Notify the physician if a regularly scheduled medication is withheld or refused for two consecutive does of a medication. b. Notify physician and responsible party if a medication is not available or not administered as scheduled. c. Medication Administration compliance reports will be reviewed in morning clinical meeting each day to ensure compliance. d. MAR□s for 20 residents will be audited for Physician and RP notification weekly for four weeks and monthly for 2 months to ensure ongoing compliance. 4) The director of nursing or designee will report results of Medication Administration compliance reports and MAR audits to the Q.A. committee for trending and analysis.	

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[milligrams] - 3 mg [2.5 mg base] / 3 mL [milliliters]; inhalation. Four times a day; 09:00 AM, 01:00 PM, 05:00 PM, 09:00 PM. Ordered By: [Name of Physician]."

Review of Resident #15's MAR (medication administration record) dated 5/1/2017 - 5/31/2017, documented the above order as follows: "Ipratropium - albuterol solution for nebulization, 0.5 mg - 3 mg (2.5 mg base) / 3 mL; inhalation. Four times a day. Dx [diagnosis]: Nasal congestion. Start / End Date: 4/28/2017 - Open Ended." The MAR contains a row for each time Resident #15 was to receive the ordered medication and a column for each date that the medication was administered. The nurse initials for the appropriate row and date when administering the medication. The nurse is also able to document comments for each date/time regarding the administration of the medication. A review of the comments on the MAR revealed Resident #15 refused the medication 37 out 77 occasions it was to be administered. The comments did not include any documentation as to whether the physician or RP were notified of the medication refusals.

A review of Resident #15's progress notes, including nursing notes and physician notes, did not reveal any documentation regarding Resident #15's refusal of the nebulizer treatments during May 2017.

A review of Resident #15's comprehensive care plan did not reveal any documentation regarding bronchitis or treatment with a respiratory nebulizer.

An interview was conducted with LPN (licensed

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practical nurse) #13 on 5/7/17 at 4:50 p.m., regarding the process followed by staff when a resident refuses medication. LPN #13 stated, "I try to convince them to take the medication and if they just refuse then I document the refusal and I contact the doctor if he is here. If the doctor is not here I tell the RN (registered nurse) on staff." LPN #13 was asked what staff do if a resident continues to refuse medications. LPN #13 stated, "I would keep putting in a note and relay the refusals to the charge nurse. I would comment during shift change and document in my notes (progress notes). The medication would probably need to be discontinued."

On 6/7/17 at 4:55 p.m. an interview was conducted with RN (registered nurse) #5, a charge nurse. RN #5 was asked about the process followed by staff when a resident refused their medications. RN #5 stated, "I would try to administer a couple of times and note that the resident had refused the medication then I would let the MD (medical doctor) know right away if it was really important and document in the progress notes and/or in the MAR." When asked if a breathing treatment would be considered important, RN #5 stated it was and she would let the MD know. RN #5 stated, "The doctor should always be notified."

An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time. A policy was requested regarding medication refusal and

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notification at this time.

On 6/8/17 at 8:10 a.m. an interview was conducted with LPN (licensed practical nurse) #12. LPN #12 was asked to describe the process followed by staff when a resident refused medications. LPN #12 stated, "I call the responsible party and let the doctor know. But a lot of times the doctor really doesn't care, but we are supposed to do it." LPN #12 was asked when she called the doctor, LPN #12 stated, "We call the doctor every time." LPN #12 was asked whether or not she documented that the resident had refused the medications and that the RP and MD were made aware. LPN #12 stated, "Yes, if I called him (the doctor) I would document in the progress notes." LPN #12 was asked if she took care of Resident #15, LPN stated that she did. LPN #12 was asked if Resident #15 ever refused her medications, LPN #12 stated, "She [Resident #15] sometimes refuses her nebulizer treatments." LPN #12 was asked what she did when Resident #15 refused her nebulizer treatments, LPN #12 stated, "When she refuses her treatments, do the next one [next scheduled treatment]. There's nothing I can do if she refuses." When asked if she notified the MD when resident #15 refused her breathing treatment, LPN #12 stated, "Sometimes I do but sometimes there's just a lot going on in the moment." LPN #12 was shown the May 2017 MAR and the number of times Resident #15 had refused her nebulizer treatment. LPN #12 was asked if the MD and/or RP should have been notified each time Resident #15 had refused her nebulizer treatments. LPN #12 stated, "To be honest I would just say the RP." When LPN #12 was asked why Resident #15 was receiving nebulizer treatments, LPN #12 stated, "I float

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from unit to unit, I am not sure, though I am pretty sure it's for a respiratory issue." LPN #12 was asked whether or not it was important for Resident #15 to receive her nebulizer treatments, LPN #12 stated, "I would say so."

On 6/8/17 at 8:45 a.m. an interview was conducted with LPN #3, the unit manager on Resident #15's unit. LPN #3 was asked what staff should do when a resident refused a medication. LPN #3 stated, "Notify the MD after the 3rd refusal. If there is a pattern of refusal I would notify the MD, especially if the medication was important." LPN #3 was asked if a nebulizer treatment would be considered important. LPN #3 stated, "I would notify the MD." LPN #3 was asked who was responsible for notifying the MD, LPN #3 stated that the nurse administering the medication was responsible for MD/RP notification. LPN #3 was shown Resident #15's May 2017 MAR and the number of times that Resident #15 had refused the medication. LPN #3 was asked whether or not the MD/RP should have been notified. LPN #3 stated that the MD / RP should have been notified. LPN #3 was asked why Resident #15 was receiving the nebulizer treatments; LPN #3 stated that it was to treat a cough / bronchitis (a respiratory illness). LPN #3 further stated, "We discontinued this medication yesterday and changed the order to PRN (as needed)."

A review of the facility document titled, "Medication Administration - General Policies and Procedures" revealed, in part, the following documentation; "22. If a dose of the regularly-scheduled medication is withheld, refused, or given at a time other than the scheduled time, the space provided to record that

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dose is initialed and circled. An explanatory note is entered on the reverse side of the MAR. If two consecutive doses of a medication are withheld or refused, the physician is notified."

No further information was provided prior to the end of the survey process.

(1) Ipratropium - albuterol is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601063.html

(2) A nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. Medicine goes into your lungs as you take slow, deep breaths for 10 to 15 minutes. It is easy and pleasant to breathe the medicine into your lungs this way. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000006.htm

2. The facility staff failed to notify the physician that a medication prescribed for Resident #3 was not available on 10/10/16 and 12/27/16.

Resident #3 was admitted to the facility on 12/6/13 and readmitted on 4/29/14 with

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diagnoses that included but were not limited to spinal stenosis, Myasthenia gravis [1], heart failure, type two diabetes mellitus, chronic kidney disease, glaucoma, osteoarthritis and venous insufficiency. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/5/17. Resident #3 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #3's June 2017 POS (physician order sheet) revealed the following eye drop order:
"Latanoprost [2] drops; 0.005%; amt [amount]: 1 drop to each eye; ophthalmic DX [diagnoses]: Unspecified open -angle glaucoma, moderate stage. At Bedtime; 09:00 PM." This order was initiated on 4/29/2014.

Review of Resident #3's August 2016 through June 2017 MARS (Medication Administration Record) revealed Resident #3 did not receive his Latanoprost 0.005% eye drops on the following dates:
10/10/2016
12/27/2016

The following note was documented in the October 2016 MAR for 10/10/2016: "Scheduled date 10/10/2016. Scheduled time 9:00 PM. Charted Date-Time: 10/10/2016 09:53 PM. Reasons/Comments Not Administered: Drug/Item unavailable."

The following note was documented in the December 2016 MAR for 12/27/2016: "Scheduled date: 12/27/16. Scheduled time 7:00 PM. Charted

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Date-Time: 12/27/2016 06:05 PM.
Reasons/Comments: Not Administered: Drug/Item Unavailable Comment: faxed over to pharmacy."

Review of the nursing notes failed to reveal why Resident #3 did not receive his eye drops. There was no evidence in the clinical record that the physician was notified.

On 6/7/17 at 9:00 a.m., an interview was conducted with Resident #3. When asked if he gets all medications at the scheduled time, Resident #3 stated that there was a few times in the past when his eye drops were not available from pharmacy. Resident #3 stated that this happened last year. Resident #3 stated that he made everyone aware that he did not receive his eye drops and the issue has since been resolved. When asked about his vision, Resident #3 stated, "I'm just going blind."

On 6/7/17 at 1:40 p.m., an interview was conducted with ASM (administrative staff member) #6, Resident #3's physician assistant. When asked what she would expect nurses to do if a resident ran out of medication, ASM #6 stated that she would expect nursing to notify her or the physician. ASM #6 stated that her orders or directions in response to being notified would depend on the type of medication missed. ASM #6 stated that for Resident #3, she would expect nursing to also notify his eye physician. When asked if missing one dose of Lantanoprost eye drops in one month would have any impact on the Resident #3, ASM #6 stated, "With my basic knowledge of Lantanoprost drops, missing a dose could increase the pressure in the eyes which could have detrimental effects." ASM #6 could

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not recall the above events. ASM #6 could not recall if she was made aware that Resident #3's eye drops were missing on 10/10/16 and 12/27/16.

On 6/7/17 at 5:23 p.m., an interview was conducted with LPN (licensed practical nurse) #16, the nurse who documented that the eye drops were not available on 10/10/16. LPN #16 was asked about the process followed by staff if a medication scheduled for administration is not available. LPN #16 stated that she would pull the medication from the drawer for the next day and then call pharmacy to have them send over more medication STAT (Immediately). LPN #16 was asked what staff do if a scheduled medication is not obtained from the pharmacy for administration at the time. LPN #16 stated, "Honestly I haven't had that happen. I would call the MD (medical doctor)." When asked when nurses should refill medications, LPN #16 stated, "Some medications have a line that says refill point that means it should be refilled if the medications get that low." LPN #16 stated that she also refills medications on Fridays if medications look like they might run out over the weekend. LPN #16 stated, "There are not many medication runs on the weekends." LPN #16 was asked when nursing should re-fill eye drops. LPN #16 stated, "When there is about a quarter left in the bottle." When asked if she could recall if Resident #3 received his eye drops on 10/10/16, LPN #16 stated that she had called pharmacy when she saw the eye drops were gone. LPN #16 stated that the resident did not receive his drops that night but she passed on to the night shift nurse that his drops were coming. When asked if she notified the physician that Resident #3 did not receive his eye drops that shift, LPN #16 stated,

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"I don't believe I did. It was my first week here."

On 6/8/17 at 9:46 a.m., an interview was conducted with LPN (licensed practical nurse) #3, the unit manager. When asked about the process followed by staff if a medication is not available to be administered, LPN #3 stated he would expect nurses to call pharmacy and have them send the medication. LPN #3 also stated he would expect nurses to call the physician so the physician can give a verbal order to hold the medication until it arrived to the facility. LPN #3 stated he expected nurses to document this information in the nursing notes. LPN #3 stated medications should be refilled two days before they run out.

On 6/8/17 at 10:17 a.m., an interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 was asked about the process followed by staff if a resident's medication ran out when it was supposed to be administered. ASM #2 stated that she would expect her nurses to call the pharmacy if the STAT box (a box containing various medications) did not carry the medication, and to have the pharmacy send the medication STAT. ASM #2 stated she would expect her nurses to notify the MD (medical doctor) if the resident could not get their scheduled dose of medication.

On 6/8/17 at 11:08 a.m., an interview was conducted with RN (registered nurse) #5, the nurse supervisor, regarding the process followed by staff when scheduled medications have run out and are not available for administration. RN #5 stated that nursing should be checking the STAT box first to see if the medication is in there. RN #5 stated that if the medication is not

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available in the STAT box, nursing should call pharmacy and have pharmacy send over medications STAT. RN #5 stated that nursing should also be notifying the physician so the physician can give a verbal order to hold the medication until it arrives from pharmacy. When asked if it should be documented that the physician was notified, RN #5 stated, "Yes, there is a comment area on the MAR."

On 6/8/17 at 9:55 a.m., an interview was conducted with OSM (Other Staff Member) #12, the pharmacist. When asked the impact of a resident missing one dose of Lantanoprost eye drops one day out of one month, OSM #12 stated, "Looking at this study it says that Lantanoprost drops hold its effectiveness for at least 24 hours. There should be no effect with missing one dose."

The nurse who administered the medication on 12/27/16 could not be reached for an interview.

On 6/8/17 at 12:05 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

[1] "Myasthenia gravis is a disease that causes weakness in your voluntary muscles. These are the muscles that you control. For example, you may have weakness in the muscles for eye movement, facial expressions, and swallowing. You can also have weakness in other muscles. This weakness gets worse with activity, and better with rest." This information was obtained from The National Institutes of Health. https://medlineplus.gov/myastheniagravis.html.

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[2] "Latanoprost is used to treat certain kinds of glaucoma. It is also used to treat a condition called hypertension of the eye. Latanoprost appears to work by increasing the outflow of fluid from the eye. It decreases pressure in the eye." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010869/?report=details.

3. The facility staff failed to make the physician aware medications were not administered to Resident #22 on 5/25/17.

Resident #22 was admitted to the facility on 5/25/17. Resident #22's diagnoses included but were not limited to: heart disease, high blood pressure and generalized anxiety disorder. Resident #22's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 6/1/17, coded the resident's cognition as moderately impaired.

Review of Resident #22's clinical record revealed a nurse's note dated 5/25/17 that documented the resident was admitted to the facility on that day at 4:00 p.m.

Resident #22's admission physician's orders dated 5/25/17 documented orders for atorvastatin (1) 20 mg (milligrams) once a day at 9:00 p.m. and donepezil (2) 5 mg once a day at 9:00 p.m.

Resident #22's May 2017 MAR (medication administration record) documented atorvastatin 20 mg and donepezil 5 mg were not administered on 5/25/17 at 9:00 p.m. The MAR notes

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documented, "Not Administered: On Hold. Comment: give as soon as in from pharmacy." The MAR and nurses' notes for 5/25/17 failed to document the medications were given that night or that Resident #22's physician was notified.

Resident #22's comprehensive care plan revised on 5/31/17 documented, "Resident requires a therapeutic diet to address heart disease...Administer medications as prescribed...'

The nurse responsible for administering 9:00 p.m. medications to Resident #22 on 5/25/17 was not available for interview.

On 6/8/17 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated nurses are supposed to notify the physician if a medication is not administered because the medication is not in the facility STAT (Immediately) box (a box containing various medications) or because the medication is not coming in time from the pharmacy. LPN #3 stated nurses should document physician notification in progress notes.

On 6/8/17 at 10:00 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality assurance clinical nurse consultant) were made aware of the above concern.

No further information was presented prior to exit.

(1) Atorvastatin is used to treat high cholesterol. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=786a6f14-1e2d-4c2a-93dd-c45315aff4fd

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F 157	Continued From page 15 (2) Donepezil is used to treat dementia (mental changes and memory loss). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010014/?report=details	F 157		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 167		7/19/17

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F 167	Continued From page 16 Based on observation and staff interview, it was determined that the facility staff failed to post notice that three years of the survey results were available upon request. Notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plans of correction, were available for review upon request. The findings include: Observation was made of the survey results book in the front lobby (reception area) on 6/6/17 at 11:15 a.m. and on 6/7/17 at 11:00 a.m. The book was located next to the sign stating, "Survey Results." The book on the table contained the survey results and plans of correction from the annual survey ending on 6/9/16 and an abbreviated survey ending on 11/11/16. During an interview on 6/7/17 at 3:12 p.m. with ASM (administrative staff member) #1, the administrator, ASM # 1 was asked if he was aware that three years of survey results were to be available. ASM # 1 stated that he was aware of this and that the survey results were in the supervisors' office. When asked if there was a sign posted indicating three years of survey results were available upon request, ASM # 1 stated that there was no sign. A request was made at this time for the facility policy on the posting of survey results. During the end of day interview on 6/7/17 at 5:35 p.m. with ASM # 1, ASM # 2, the director of nurses, ASM # 3, the clinical nurse consultant, and ASM # 4, the assistant director of nurses, this	F 167	F167 Survey Book (3 years notice) 1) A notice of where to view the past three years of survey results was placed in the front of the Survey Book in the lobby area. 2) All residents and visitors who viewed the Survey Book in the lobby have the potential to be affected by the same practice. 3) The facility staff will be in-serviced on: a. Location of past three years of survey results, notice of availability in the Survey Binder. b. Public notices regarding location of most recent survey results and three (3) history are placed in prominent locations at each unit. c. The Administrator or designee will conduct an audit weekly to ensure notice is present in Survey Binder in lobby area and on units to ensure ongoing compliance with this practice. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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F 167	Continued From page 17 concern was again reviewed. At this time ASM # 1 stated that there was no policy for posting the survey results. Review of the facility's admission agreement revealed documentation regarding access to the resident's clinical record. The admission agreement documented, "#13. I understand that I have the right to examine the most recent survey of (name of facility) conducted by Federal or State Surveyors and that the results are available in the reception area, or other designated location for my review." No further information was provided prior to exit.	F 167		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 252		7/19/17

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F 252	Continued From page 18 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for two of 96 resident bathrooms, the bathroom shared by rooms 232/233 and the bathroom shared by rooms 206/207. 1. A black stain was observed on the vinyl floor around the toilet in the bathroom in between room 232 and room 233. 2. The bathroom shared by rooms 206 and 207 were observed to have a dark substance caked around the base of the commode and the flooring was observed to contain stains and dirt in the corners. The findings include: 1. A black stain was observed on the vinyl floor around the toilet in the bathroom in between room 232 and room 233. On 6/6/17 at 3:21 p.m. and 6/7/17 at 11:45 a.m. observation of the bathroom in between room 232 and 233 was conducted. A black stain was observed on the gray vinyl floor around the toilet. The stain extended from the back of the toilet to the front of the toilet. The measurements of the stain extended approximately 12 inches on the right side of the toilet and approximately five	F 252	F252 Quality of Life Maintain Clean Bathrooms 2/96 Bathrooms 1) The bathrooms shared by room 232 / 233 and 206 / 207 are clean, homelike, and comfortable. The flooring was replaced in the 232 / 233 bathroom and the toilet and floor were cleaned in the 206 / 207 bathroom. Housekeeping staff were educated on the proper cleaning of bathrooms and surrounding toilet area. 2) All residents who utilize the bathrooms at Lexington Court have the potential to be affected by the same practice. The Housekeeping Director or designee will complete a 100% audit of the resident bathrooms any similar issues will be addressed immediately. 3) Housekeeping staff will be in-serviced on: a. Cleansing of the bathrooms and surrounding toilet area. The Housekeeping Director will conduct a weekly audit of 25% of resident bathrooms to ensure ongoing compliance with this practice. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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inches on the left side of the toilet.

On 6/7/17 at 12:53 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked what should be done if she noticed a floor stain. LPN #7 stated, "We notify maintenance and let our supervisor know too." LPN #7 was shown the floor stain in the bathroom in between room 232 and room 233. LPN #7 stated, "I didn't even notice that. It looks like a water leak."

On 6/7/17 at 1:07 p.m. an interview was conducted with OSM (other staff member) #1 (the maintenance director). OSM #1 stated he looks at each resident room and bathroom once a week. OSM #1 stated housekeeping was responsible for stains on floors and he would notify the housekeeping department if he saw a stain on the floor.

On 6/7/17 at 1:15 p.m. an interview was conducted with OSM #2 (the housekeeping director). OSM #2 stated resident bathrooms are cleaned in the morning and again after lunch. OSM #2 stated the bathroom floors should be mopped each time staff cleans the bathrooms. When asked if he was aware of any bathrooms with stained floors, OSM #2 stated he was not.

On 6/7/17 at 1:22 p.m. OSM #1 and OSM #2 were shown the floor in the bathroom in between room 232 and room 233. OSM #2 stated the stain on the floor was from urine. OSM #2 stated housekeeping staff scrubs the floor with a cleaning machine but the stain remains. OSM #1 and OSM #2 were asked if the vinyl floor could be replaced. OSM #2 stated the floor could be replaced. OSM #1 stated he would have to hire a

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F 252	Continued From page 20 contractor to replace the floor. OSM #1 and OSM #2 agreed the stained floor did not look homelike. On 6/7/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the corporate quality assurance clinical nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings. The facility housekeeping department policy and procedure documented, "Purpose: Provide a clean, sanitary and comfortable environment conductive to excellent resident care and well-being..." No further information was presented prior to exit. 2. The bathroom shared by rooms 206 and 207 were observed to have a dark substance caked around the base of the commode and the flooring was observed to contain stains and dirt in the corners. The following observations were made of the bathroom between rooms 206 and 207: - During facility tour on 6/6/17 at 11:25 a.m. there was a black substance, approximately a quarter inch wide around the base of the commode. The floor was observed to have multiple stains and dirt in the corners of the room. - On 6/7/17 at 9:00 a.m. an observation was made of the bathroom and the base of the commode continued to have a dark substance approximately a quarter inch wide. The bathroom floor was unchanged.	F 252		

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On 6/7/17 at 1:00 p.m. an interview was conducted with OSM (other staff member) #1, the maintenance director. OSM #1 was asked how often the bathrooms in the resident rooms were inspected. OSM #1 stated that if staff members reported a concern to him and also by walk through, OSM #1 further stated, "I check all the resident rooms and bathrooms at least one time each week." When OSM #1 was asked if this was done every week OSM #1 stated, "All rooms are inspected the majority of times." OSM #1 was asked if there had been any concerns regarding cleanliness of the resident bathrooms, OSM #1 stated, "We let housekeeping know of any concerns." OSM #1 was asked if he had relayed any concerns to housekeeping recently. OSM #1 stated that he had not.

On 6/7/17 at 1:15 p.m. an interview was conducted with OSM #2, the housekeeping director, regarding the cleaning of resident bathrooms. OSM #2 stated the housekeeping staff cleaned the resident bathrooms in the morning and then a second time after lunch. OSM #2 also stated, "There is also a porter 3 pm to 11 pm who is on call to address any issues. The staff mops the bathroom floors during both daily cleanings." When asked, OSM #2 stated that she was not aware of any stained floors in resident bathrooms. OSM #2 and OSM #1 were shown the resident bathroom between rooms 206 and 207. Both OSM #2 and OSM #1 stated they were not aware of the condition of the bathroom and confirmed the area should have been reported to them. OSM #2 stated the area would be fixed today and both OSM #1 and OSM #2 stated the above described area did not look homelike.

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F 252	Continued From page 22 A review of the housekeeping policy titled, "Housekeeping Department Policy and Procedure" revealed, in part, the following information: "Purpose: Provide a clean sanitary and comfortable environment conductive (sic) to excellent resident care and well-being. Title: Seven Step Cleaning: Procedure: 3. Bathroom Cleaning (Daily) Mirror, sink inside and underneath, toilet inside and outside of toilet. 6. Floor Sanitizing (Daily) Wet mop or vacuum entire room." An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time. No further information was provided prior to the end of the survey process.	F 252		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain resident shower rooms in good repair in three of six facility shower rooms, (Tuckahoe Unit the Whirlpool Spa, Westham Unit the shower room nearest to resident room # 211, and on the Grove Unit the shower room across from resident room	F 253	F253 Quality of Life Maintain Shower Room Tiles 3/6 Shower rooms 1) The broken tiles were replaced in all three shower rooms. Maintenance staff were educated on timely repair of tile breakage in the shower area. 2) All residents who utilize the shower	7/19/17

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F 253	Continued From page 23 # 311). Broken tiles were observed in the Grove unit shower room across from resident room # 311, in the Whirlpool Spa on the Tuckahoe Unit, and in the Westham Unit the shower room nearest to resident room # 211. The findings include: During an observation on 6/7/17 at 6:20 a.m. of the two shower rooms on the Grove Unit, the shower room across from resident room # 311 was observed to have three broken tiles. The tiles were located on the wall between the sink and the shower stall and on the corner of the wall and on the walls on each side of the shower stall. The edges of the broken tiles were sharp. During an observation on 6/7/17 at approximately 1:10 p.m. of this shower room (Grove Unit) with OSM (other staff member) # 1, the Director of Maintenance, and OSM # 2, the Director of Housekeeping, OSM # 2 stated that this shower room was not used for resident showers. When asked about the wheelchair scale located at the far end of the shower room, OSM # 2 stated residents were brought into the shower room to be weighed and had to pass the broken tile. OSM # 1 stated that he was not aware of these broken tiles. During an observation on 6/7/17 at 6:30 a.m. of the two shower rooms on the Westham Unit, the shower room near to resident room # 211 was observed to have three broken tiles. Two broken tiles were located on the wall between the sink and the shower stall and one broken tile was on the wall between the shower stall and the	F 253	area have the potential to be affected by the same practice. The Maintenance Director completed a 100% audit / inspection of all shower areas any similar issues were addressed immediately. 3) Maintenance staff will be in-serviced on: a. Timely replacement of broken tiles in resident care areas. b. Safety in resident care areas. The Facility staff will be in-serviced on timely reporting of maintenance issues. The Maintenance Director or designee will complete a 100% monthly audit of all shower areas to ensure ongoing compliance in this area. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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commode. The edges of the broken tiles were sharp.

During an observation on 6/7/17 at approximately 1:20 p.m. of this shower room (Westham Unit) with OSM # 1 and OSM # 2, OSM # 1 stated that he was not aware of these broken tiles.

During an observation on 6/7/17 at approximately 6:35 a.m. the shower rooms on the Tuckahoe Unit were observed. The shower room identified as "Whirlpool Spa" was observed to have a broken tile on the wall between the sink and the commode.

During an observation on 6/7/17 at 1:35 p.m. of this shower room (Tuckahoe Units' Whirlpool Spa) with OSM # 1 and OSM # 2, this tile was observed. OSM # 1 stated that he was aware of the tile and was having trouble finding a tile to match the other tiles.

During an interview on 6/7/17 at 11:05 a.m. with CNA (certified nurse's assistant) # 4, CNA # 4 was asked how concerns of broken items are reported. CNA # 4 stated that staff go to the nurse's station and retrieve a slip for maintenance. Of course if staff sees maintenance then they would report the issue directly to them but staff should always fill out a slip. When asked if maintenance responded to the slips and repaired the item CNA # 4 stated that they did and the issues are taken care of.

During an interview on 6/7/17 at 1:40 p.m. with OSM # 1, OSM # 1 was asked how he learns of items that need to be repaired. OSM # 1 stated that staff fills out "service tickets" any staff can fill one out. OSM # 1 also stated that he does a

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F 253	Continued From page 25 walk through once a week and checks each room. At this time a request was made for a blank copy of the "service ticket" and the facility policy for repairs. During an interview on 6/7/17 at 3:12 p.m. with ASM (administrative staff member) #1, the administrator, ASM # 1 was made aware of the concerns in the shower rooms. A request was made at this time for the facility policy for maintenance to include the use of the work order system. During the end of day interview on 6/7/17 at 5:35 p.m. with ASM # 1, ASM # 2, the director of nurses, ASM # 3, the clinical nurse consultant, and ASM # 4, the assistant director of nurses, this concern was again reviewed. At this time ASM # 1 stated that there was no facility policy for maintenance and the use of the work order system. No further information was provided prior to exit.	F 253		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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	F 280		7/19/17

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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.

(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.

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F 280	Continued From page 27 (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 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to revise the comprehensive care plan for one of 28 residents in the survey sample, Resident #1. The facility staff failed to revise Resident #1's comprehensive care plan after the resident's wander guard (a device used to prevent elopement) was discontinued. The findings include:	F 280	F 280 Comprehensive Person Centered Care / Care Plan 1) The Care Plan for resident # 1 was updated to reflect the removal of the Wander-guard from the resident□s care plan. The licensed nursing staff and Interdisciplinary team were educated on the timely updating of resident care plans. 2) All residents who have worn a Wander-guard have the potential to be affected by the same practice. The Director of Nursing or designee will	

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F 280	Continued From page 28 Resident #1 was admitted to the facility on 10/14/10. Resident #1's diagnoses included but were not limited to: chronic kidney disease, major depressive disorder and anxiety disorder. Resident #1's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/15/17, coded the resident's cognitive skills for daily decision making as severely impaired. Review of Resident #1's clinical record revealed a physician's order dated 5/1/17 to discontinue the resident's wander guard. Resident #1's comprehensive care plan revised on 5/31/17 documented, "Resident is at risk for elopement and wandering due to: Moderate Elopement Risk Assessment Score- medications that may alter mental status/ alert/ and ambulatory...Ensure placement of wandering bracelet. Check functionality daily..." On 6/7/17 at 8:08 a.m. an interview was conducted with RN (registered nurse) #1 (the newly employed unit manager). RN #1 stated she revises residents' care plans at the quarterly care plan meetings held on each Wednesday. RN #1 stated LPN (licensed practical nurse) #8 (the quality improvement director) also periodically revises care plans. When asked if Resident #1 had a wander guard, RN #1 stated she thought the wander guard was discontinued. When asked if the resident's care plan should be updated to reflect the discontinuation of the wander guard, RN #1stated, "Yes." On 6/7/17 at 9:46 a.m., RN #1 confirmed Resident #1 did not have a wander guard. RN #1	F 280	complete a 100% audit of all current residents who wear a Wander guard or have worn a Wander guard in the past 6 months, any similar issues will be addressed immediately. 3) a. New orders for wander-guards will be reviewed in the morning clinical meeting daily and care plans will be updated. All residents with care plan updates for current or discharged orders for wander-guards will be reviewed monthly in facility risk meeting to ensure ongoing compliance. b. The licensed nursing staff and interdisciplinary team were provided education on updating approaches on current care plan when changes occur. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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F 280	Continued From page 29 stated staff had just updated the resident's care plan. On 6/7/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the corporate quality assurance clinical nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings. The facility policy titled, "CARE PLANNING" documented, "The plan of care for each resident is person-centered and updated when needed with episodic change of conditions and reviewed/revised periodically..." No further information was presented prior to exit.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 28 residents in the survey sample, Resident #16 and Resident #20. 1. On 6/6/17 the facility staff was observed to administer Furosemide (1), a diuretic, 80 mg	F 281	F281-Services provided to meet professional standards of quality 1) The physician was contacted regarding Resident #16 receiving incorrect dose of Lasix and Lasix 40mg BID is currently given per physician order. The physician was contacted regarding Resident #20□s order for cranberry capsules and an order to increase the	7/19/17

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F 281	Continued From page 30 (milligrams) to Resident #16 rather than Furosemide 20 mg as ordered by the physician. Between 5/26/17 and 6/6/17 the facility staff documented that they administered Furosemide 20 mg (milligrams) to Resident #16 during which time the facility was only receiving Furosemide 80 mg from the pharmacy. 2. The facility staff failed to administer the correct dose of a cranberry capsule to Resident #20 and failed to clarify the physician's order for the cranberry capsule. The findings include: 1. On 6/6/17 the facility staff was observed to administer Furosemide (1), a diuretic, 80 mg (milligrams) to Resident #16 rather than Furosemide 20 mg as ordered by the physician. Between 5/26/17 and 6/6/17 the facility staff documented that they administered Furosemide 20 mg (milligrams) to Resident #16 during which time the facility was only receiving Furosemide 80 mg from the pharmacy. Resident #16 was admitted to the facility on 12/10/16 with diagnoses that included, but were not limited to; chronic obstructive pulmonary disease, heart failure, diabetes, peripheral vascular disease and high blood pressure. Resident #16's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 3/15/17. Resident #16 was coded as scoring eight out of a possible 15 in Section C, Cognitive Patterns, BIMS (brief interview for mental status), indicating that Resident #16 is moderately cognitively impaired with daily decision making.	F 281	dose to the available stock medication was received. The Licensed Nursing staff was provided education on medication administration consistent with professional standard of practice. Pharmacy staff was reeducated on the proper implementation of medication orders originating from the facility□s electronic health record (completed 6/26/17). 2) a. All residents who receive medications from Remedi pharmacy have the potential to be affected by the same practice. The pharmacy will complete a 100% medication reconciliation audit, comparing current medication orders in the medical record with the medication dispensed from the pharmacy, by July 7, 2017. Any discrepancies will be reported immediately to the Director of Nursing to be reconciled. b. All residents who receive cranberry capsules over the counter medications from central supply have the potential to be affected by the same practice. The facility staff, DON, or designee will complete a 100% audit of all cranberry capsules OTC medications with MAR orders to insure appropriate dosage of OTC medication compared to physician order. 3) a. The Licensed Nursing staff were educated on: 1. Medication administration consistent with professional standards of practice. 2. Verifying dosage on Paxit bags and or medication packet compared to physician order in the Medication administration record to ensure medication is given per	

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F 281	Continued From page 31 During medication administration observation on 6/7/17 at 8:30 a.m. LPN (licensed practical nurse) #9 was observed administering Furosemide, a diuretic, 80 mg (milligrams). The medication was individually wrapped with a label and placed in a sealed bag, along with other medications to be administered on 6/7/17 at 9:00 a.m., and a list of the medications enclosed printed on the sealed bag. LPN #9 was observed comparing the list on the sealed bag with the electronic MAR. LPN #9 then opened the bag and removed the individually wrapped medications to be administered. LPN #9 then proceeded to compare the contents of the package with the list on the front of the package and the MAR. LPN #9 handed the package to this writer, the package documented Furosemide 80 mg, which was then listed and entered onto the Medication Administration Observation form. LPN #9 was then observed emptying the package containing Furosemide 80 mg into a cup. LPN #9 then handed the empty package to this writer to confirm that the content of the package was Furosemide 80 mg. LPN #9 then proceeded to administer the Furosemide 80 mg to Resident #16 along with ten other ordered medications that were verified in the same manner as described for the Furosemide. A review of Resident #16's clinical record revealed, in part, the following physician order; dated 5/26/17, "Lasix (furosemide) tablet; 20 mg: amt (amount): 1 (one) tab (tablet): oral. Twice a Day. 09:00 AM, 05:00 PM." A review of Resident #16's MAR dated 5/1/17 - 5/31/17 revealed, in part, the following: "Order: Lasix (furosemide) tablet; 20 mg; Amount to Administer; 1 tab; oral. Frequency: Twice A Day.	F 281	the physician order. b. The pharmacy staff were educated on the proper implementation of medication orders originating from the facility□s electronic health record (completed 6/26/17). c. Remedi Pharmacy will complete a 100% monthly reconciliation audit again in August and September of 2017 comparing current medication orders in the medical record with medication being dispensed from the pharmacy and any discrepancies will be immediately reported to the Director of Nursing to be reconciled. d. DON or designee will complete a monthly audit on new OTC cranberry capsule medication orders to ensure facility supply dose matches the physician order. 4) Results of the audits will be presented to Quality Assurance committee for review and recommendations.	

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Start / End Date 5/26/2017 - 6/7/2017 (DC Date)." Under the columns for each date between 5/26/17 and 5/31/17 there were nursing initials documented, indicating administration of Furosemide 20 mg, at 9:00 a.m. and 5:00 p.m. each day.

A review of Resident #16's MAR (medication administration record) dated 6/1/17 - 6/7/17 revealed, in part, the following documentation: "Order: Lasix (furosemide) tablet; 20 mg (milligrams); Amount to Administer: 1 tab: oral. Frequency: Twice a Day. Diagnosis: [Dx (diagnosis): Unspecified diastolic (congestive) heart failure]. Start / End Date: 5/26/2017 - 6/7/2017 (DC (discontinue) Date)." LPN #9's initials were documented on 6/7/17 at 9:00 a.m., indicating that Furosemide 20 mg was administered.

Further review of Resident #16's June 2017 MAR revealed nursing initials under each date column (indicating that Resident #16 had received Furosemide 20 mg twice a day) from 6/1/2017 through 6/7/2017.

A review of the monthly pharmacy medication review did not reveal any documentation regarding the Furosemide dosing.

On 6/7/17 at 1:00 p.m. LPN #9 was asked to open her medication cart and to pull out the medications ordered for Resident #16. Medications for all Residents were separated by time of administration and contained in sealed bags sorted by administration time. The only sealed bag for Resident #16 was for the medications to be administered at 5:00 p.m. on 6/7/17. The contents listed on the sealed bag

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included Furosemide 80 mg. Further inspection of the individual packets contained inside the sealed bag revealed one dose of Furosemide 80 mg.

LPN #9 was asked to access Resident #16's electronic MAR and to show this writer the physician order for Furosemide 80 mg. LPN #9 stated that the MAR listed Furosemide 20 mg to be administered twice a day. LPN #9 further stated that the order for Furosemide 20 mg had been discontinued and a new order for Furosemide 40 mg had been initiated to start on 6/7/17 at 5:00 p.m. LPN #9 was asked if she remembered administering Furosemide to Resident #16 that morning. LPN #9 stated that she did remember that she "threw away a dose because it wasn't right." When asked when she threw the incorrect dose away LPN #9 stated, "Before administering her (Resident #16's) meds (medications)." LPN #9 was asked if she remembered this writer's process prior to the administration of the medications. LPN #9 stated that she remembered that this surveyor wrote down each medication from the sealed package and then compared this to each medication contained within the sealed package. LPN #9 was asked again when she threw away the incorrect dose of Furosemide. LPN #9 stated, "I must have given it to her."

LPN #9 was asked to describe the process when administering medications. LPN #9 stated, "I should do the six rights." When asked to state the "six rights" LPN #9 responded, "Right medication, right patient, right dose and right time. I don't remember the other two." LPN #9 was asked how she verified the right dose. LPN #9 stated that she would compare the packaging

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with the electronic MAR prior to administering the medications. LPN #9 further stated, "I probably skipped over that dose this morning." When asked how the medications are delivered and checked into the facility, LPN #9 stated, "They are delivered between 12:00 a.m. and 1:00 a.m. and the night shift nurse checks them in. The pharmacy brings the next day's delivery and the nurse just checks them off from his list to make sure the delivery matches. The medications are not checked at that time against the MARs, the nurse delivering the medications checks that off prior to administering."

On 6/7/17 at approximately 1:10 p.m. an interview was conducted with OSM (other staff member) #9, the pharmacist. OSM #9 was asked how he received orders for medications to be filled from the facility. OSM #9 stated that it was through their automated system, as an order was entered it went directly to the pharmacy. OSM #9 was asked to look at Resident #16's medication orders and was asked to state the dosage for the current Furosemide order on file at the pharmacy. OSM #9 stated that the order for Furosemide had changed that day (6/7/17) from 80 mg twice a day to 40 mg twice a day. When asked how long the order for Furosemide 80 mg had been in place, OSM stated, "Furosemide was ordered originally on 12/19/16 for 80 mg and that is what has been sent since that date." When asked if there were any other orders for a different Furosemide dose in the pharmacy system, OSM #9 stated, "There are no other doses in our system."

On 6/7/17 at approximately 1:40 p.m. LPN #8, the director for compliance of quality improvement, was asked to obtain a pharmacy manifest for all medications delivered for Resident #16 beginning

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on 5/25/17 through 6/7/17.

On 6/7/17 at 3:50 p.m. LPN #8, the director for compliance of quality improvement, provided a pharmacy delivery manifest dated 6/6/17 that documented, a delivery of two Furosemide 80 mg tablets for Resident #16. There was no documentation to indicate that Furosemide 20 mg tablets had been delivered. When asked why the pharmacy was delivering Furosemide 80 mg when the physician order documented Furosemide 20 mg, LPN #8 stated that she did not know but was getting the pharmacy to "look into it." LPN #8 was asked again to provide the delivery manifests for Resident #16 from 5/26/17 through 6/7/17.

An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time, and the request for the delivery manifest from 5/26/17 through 6/7/17. A request was also made for any documentation that would evidence the nursing staff were discarding the Furosemide 80 mg dose and were obtaining the Furosemide 20 mg to administer to Resident #16. A policy was also requested at this time regarding medication administration and medication requisition from the pharmacy.

On 6/8/17 at 8:45 a.m. an interview was conducted with LPN #1, the unit manager on Resident #16's unit. When asked what a nurse should do when getting ready to administer a

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medication LPN #1 stated, "There should be three checks, check the sealed bag against the MAR, check the resident's identity, and check the route for the medication to be delivered. The five rights should be completed, right med, right dose and right time. Then the nurse has to check each pill package within the bag against the MAR to ensure that the bag and contents match the MAR." When asked what happens when the medications delivered do not match the order on the MAR, LPN #1 stated that the order / medication delivered should be verified. LPN #1 was asked about Resident #16's Furosemide order. LPN #1 stated, "I don't know what happened there, it should have been questioned."

On 6/8/17 at 10:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to describe the process followed by nursing when administering a medication to a resident. ASM #2 stated, "Identify the patient, conduct six rights of medication administration and check the medication against the MAR." When asked what the nursing staff should do if the MAR and medication available do not match, ASM #2 stated that the nurse should clarify the order and the medication.

On 6/8/17 at approximately 10:30 a.m. a pharmacy delivery manifest was provided that documented the delivery of Furosemide for Resident #16 since 12/20/2016. For the dates 5/25/17 through 6/8/17 the manifest documented that only Furosemide 80 mg was delivered for administration to Resident #16.

On 6/8/17 at 11:45 a.m. an interview was conducted with LPN #8. LPN #8 was asked what

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dose of Furosemide the nursing staff was administering to Resident #16 between 5/26/17 and 6/7/17. LPN #8 stated, "I am thinking that when nursing compared the doses provided with the MAR they just threw away the 80 mg dose." When asked if she knew for certain that the Furosemide 80 mg was being discarded every day, twice a day since 5/26/17, LPN #8 stated, "No I do not." When asked if the nursing staff were discarding the Furosemide 80 mg where the nurses were getting the correct dose from, LPN #8 stated, "I don't know, maybe the STAT (Immediately - emergency medication) box." LPN #8 was asked to provide evidence that the nursing staff was retrieving Furosemide 20 mg from the STAT box twice a day since 5/26/17. LPN #8 was asked what nursing should do if they receive two different doses of medication. LPN #8 stated, "I don't know." LPN #8 was asked whether or not nursing should clarify the order with the physician and pharmacy. LPN #8 stated, "Yes." When asked what nursing did about the incorrect dose being delivered for Resident #16, LPN #8 stated, "I can't say."

On 6/8/17 at 12:10 p.m. an interview was conducted with RN (registered nurse) #3. RN #3 was asked to describe how the pharmacy delivered medications to the facility. RN #3 stated, "They send individually sealed bags with the medications due for the next date. Each bag contains a list of medications contained in the bag for a specific time." When asked what staff do if the bag has an incorrect dose listed. RN #3 stated, "We go by the MAR, regardless of what the bag shows because the pharmacy delivers in advance and the order may have changed. If there is a discrepancy we should research the discrepancy and call the pharmacy to reduce the

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risk of a med (medication) error. If the dose and the MAR do not match I should definitely call the pharmacy."

On 6/8/17 at approximately 1:00 p.m. LPN #8 provided documentation from the STAT box that evidence that on 6/4/17 at 5:00 p.m. a nurse retrieved Furosemide 20 mg to administer to Resident #16. LPN #8 stated this was the only documentation since prior to 5/26/17 that a nurse had retrieved Furosemide 20 mg from the STAT box to administer to Resident #16.

A review of the facility policy titled, "Medication Administration - General Policies and Procedures" revealed, in part, the following documentation; "Policy: Medications are only administered as prescribed in accordance with good nursing principles and practices and by legally - authorized persons. Procedure: 1. C. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. 5. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition the nurse calls the provider pharmacy for clarification prior to the administration of the medication. The interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere, as appropriate, in the medical record. 20. The

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resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration."

No further information was provided prior to the end of the survey process.

(1) Furosemide is used alone or in combination with other medications to treat high blood pressure. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine. This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682858.html

2. The facility staff failed to administer the correct dose of a cranberry capsule (1) to Resident #20 and failed to clarify the physician's order for the cranberry capsule.

Resident #20 was admitted to the facility on 7/1/16. Resident #20's diagnoses included but were not limited to: pneumonia, urinary tract infection and high blood pressure. Resident #20's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/17, coded the resident as cognitively intact.

Review of Resident #20's clinical record revealed a physician's order dated 2/15/17 for an over the counter cranberry capsule- 400 mg (milligrams) twice a day. Resident #20's June 2017 MAR (medication administration record) documented an order for a cranberry capsule- 400 mg twice a

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day.

A MAR note dated 6/5/17 documented Resident #20's cranberry capsule was not administered because the item was not available.

On 6/8/17 at 9:48 a.m., observation of the over the counter medications in the facility central supply was conducted with OSM (other staff member) #8 (the central supply employee). Cranberry capsules- 425 mg were observed. OSM #8 stated she could only order that dose of cranberry capsules.

On 6/8/17 at 10:00 a.m. this surveyor asked ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality assurance clinical nurse consultant) to provide the pharmacy manifest for Resident #20's cranberry capsule to evidence when the capsule was delivered to the facility.

On 6/8/17 at 12:35 p.m. LPN (licensed practical nurse) #8 stated there was no pharmacy manifest for Resident #20's cranberry capsule because the capsule was obtained from the bulk medications in the facility central supply. LPN #8 was made aware the cranberry capsules available in central supply were 425 mg capsules and Resident #20's physician order was for 400 mg capsules. LPN #8 was asked if Resident #20 had been receiving 425 mg capsules. LPN #8 stated she would say the 425 mg capsules were the capsules pulled from central supply and the order needed to be clarified.

On 6/8/17 at 12:40 p.m. the medication cart containing Resident #20's medications was observed by this surveyor and LPN #4. LPN #4

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was asked to show this surveyor Resident #20's cranberry capsules. LPN #4 pulled out a bottle of cranberry capsules that were 425 mg. LPN #4 confirmed Resident #20 had been administered the 425 mg capsules although the physician's order was for 400 mg. LPN #4 stated she was waiting for clarification from the physician. LPN #4 was asked the facility process to ensure medications are administered per physician's orders. LPN #4 stated she checks the MAR and checks the bottle containing the cranberry capsules. LPN #4 was asked what should be done if the dose on the bottle doesn't match the dose written on the MAR. LPN #4 stated she should obtain clarification from the physician. LPN #4 stated she didn't notice there was a difference in the dose of the cranberry capsule prescribed by the physician and the dose that was contained in the bottle.

On 6/8/17 at 1:10 p.m., ASM (administrative staff member) #1 and ASM #3 were made aware of the above findings and asked what standard of practice the facility staff follows regarding order clarification and medication administration. ASM #3 stated staff follows the facility policies.

The facility policy titled, "MEDICATION ADMINISTRATION- General Policies and Procedures" documented, "C. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule..."

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F 281	Continued From page 42 No further information was presented prior to exit. (1) Cranberry capsules are prescribed for the prevention of urinary tract infections. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/25180378	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review it was determined that the facility staff failed to follow the written plan of care for two of 28 residents in the survey sample, Residents # 6 and # 14. 1. The facility staff failed to follow the comprehensive care plan for the use of non-pharmacological interventions for Resident # 6. 2. The facility staff failed to follow the comprehensive care plan for the use of a fall mat for Resident # 14. The findings include: 1. The facility staff failed to follow the	F 282	F282 Services by qualified persons/per care plan 1) The Bedside mat order for resident # 14 was discontinued as a current approach and was removed from the care plan. The non-pharmacological documentation was added to the MAR on resident #6. Licensed Nursing staff # (11) was educated on timely updating of approaches on the care plan per facility policy and Documenting non-pharmacological pain interventions as written on the care plan. 2) All residents who have current orders for bedside mats have the potential to be affected by the same practice. All residents with orders for PRN medications for pain have the potential to be affected by the same practice. The Director of	7/19/17

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F 282	Continued From page 43 comprehensive care plan for the use of non-pharmacological interventions for Resident # 6. Resident # 6 was admitted to the facility on 04/20/17 with diagnoses that included but were not limited to: lung cancer, diabetes mellitus (1), history of breast cancer, hypertension (2), gastroesophageal reflux disease (3), pain and fibromyalgia (4). Resident # 6's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/27/17, coded Resident # 6 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 6 was coded as requiring extensive assistance of one staff member for activities of daily living. The POS (Physician's Order Sheet) for Resident # 6 dated 06/01/2017 - 06/07/2017 documented, "Start Date: 04/26/2017. Oxycodone (5) - tablet; 5 (five) MG (milligrams): 1 (one) tablet; oral (by mouth). Special instructions: PRN (as needed) for Moderate - Severe pain. Every 4 (four) hours." The care plan for Resident # 6 dated 04/20/2017 documented, "Problem: Category - Pain. Alteration in comfort due to fibromyalgia, lung cancer, djd (degenerative joint disease) and gallstones." Under "Approach" it documented, "Approach Start Date: 04/20/2017. Attempt non-pharmacological approaches. Document attempts and effectiveness. Edited: 05/09/2017." The eMAR (electronic medication administration record) for Resident # 6 dated 05/01/2017 -	F 282	Nursing or designee will complete a 100% audit of all current residents who have orders or discontinued orders for bedside mats to ensure their care plan reflects current orders in the past 90 days. All residents who receive PRN pain medication will be audited to ensure documentation of non-pharmacological approaches on the MAR and care planned appropriately, any similar issues will be addressed immediately. 3) The Licensed Nursing staff were educated on: a. Timely updating of the Care Plan approaches per facility policy. b. Ensuring documentation of non-pharmacological interventions. The Director of Nursing or designee will complete a monthly audit x 3 months of all residents with bedside mats or discontinued bedside mats within the last 30 days to ensure ongoing compliance with care plan updates and all orders to discontinue bedside mats will be reviewed in clinical meeting daily with an appropriate care plan update. New admissions will be reviewed daily in Clinical meeting to ensure non-pharmacological intervention documentation is implemented and reflected on the care plan. Weekly audit of all new PRN pain orders to ensure availability to document non-pharmacological interventions on MAR and appropriate care plan updates 4) Results of the audit are presented to Quality Assurance committee for review and recommendations.	

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05/31/2017 documented, "Oxycodone - tablet; 5 MG. Amount to Administer: 1 (one) tablet; oral."

The eMAR dated 05/01/2017 - 05/31/2017 documented Oxycodone tablet; 5 MG was administered on the following dates and times: 05/01/17 at 4:45 a.m. and at 9:53 a.m., 05/02/17 at 5:04 a.m. and at 10:02 a.m., 05/03/17 at 4:57 a.m., 05/04/17 at 9:20 a.m., 05/05/17 at 5:01 a.m. and at 2:23 p.m., 05/06/17 at 5:06 a.m., 05/07/17 at 4:57 a.m., 05/08/17 at 5:11 a.m., 05/09/17 at 4:50 a.m., 05/10/17 at 5:02 a.m., 05/11/17 at 5:45 a.m., 05/12/17 at 9:27 a.m. and at 6:24 p.m., 05/14/17 at 8:35 a.m., 05/15/17 at 9:20 a.m., 05/16/17 at 9:30 a.m., 05/18/17 at 9:27 a.m., 05/19/17 at 4:59 a.m., 05/20/17 at 4:48 a.m. and at 9:40 a.m., 05/21/17 at 2:54 a.m., 05/24/17 at 1:05 p.m., 05/26/17 at 8:40 p.m., 05/27/17 at 7:20 a.m. and at 2:48 p.m., 05/29/17 at 8:49 p.m., and on 05/30/17 at 8:26 a.m. The eMAR coded for each date the Oxycodone 5 MG tablet was administered documented, "E (effective)."

The eMAR dated 05/01/2017 - 05/31/2017 failed to evidence documentation of non-pharmacological approaches.

The facility's "Progress Notes" for Resident # 6 dated 05/01/2017 - 05/31/2017 failed to evidence documentation of attempted and or implemented non-pharmacological approaches.

On 06/07/17 at 10:15 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager. When asked to describe the purpose of the care plan LPN # 3 stated, "It shows the issues, problems, behaviors, long and short term goals and interventions." When asked if interventions, procedures or treatments

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documented on the care plan should be implemented, LPN # 3 stated, "Yes." After reviewing the Resident #6's May 2017 eMAR, progress notes and pain care plan, LPN # 3 was asked if non-pharmacological interventions were implemented. LPN # 3 stated, "No." When asked if Resident # 6's care plan was being followed LPN # 3 stated, "No."

On 06/07/17 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) # 17. When asked to describe the purpose of the care plan LPN # 17 stated, "Helps you care for the resident." LPN #17 was asked if an intervention, procedure or treatment documented on the care plan should be implemented. LPN # 17 stated, "Yes." After reviewing the Resident #6's May 2017 eMAR, progress notes and pain care plan, LPN # 17 was asked if non-pharmacological interventions were implemented. LPN # 17 stated, "No." When asked if Resident # 6's care plan was being followed, LPN # 3 stated, "No."

The facility's policy "Care Planning" documented, "5. The Comprehensive Care Plan will describe: a. The services furnished to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including trauma related care needs."

On 06/08/17 at approximately 12:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

References:

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(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) A common syndrome in which a person has long-term pain that is spread throughout the body. The pain is most often linked to fatigue, sleep problems, headaches, depression, and anxiety.
People with fibromyalgia may also have tenderness in the joints, muscles, tendons, and other soft tissues. This information was obtained from the website: https: https://medlineplus.gov/ency/article/000427.htm.

(5) Oxycodone is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682132.h

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tml.

2. The facility staff failed to follow the comprehensive care plan for the use of a fall mat for Resident # 14.

Resident # 14 was readmitted to the facility on 03/23/16 with diagnoses that included but were not limited to: atrial fibrillation (1), gastroesophageal reflux disease (2), clostridium difficile [C. difficile] (3), diabetes mellitus (4), schizophrenia (5), hypertension (6), chronic obstructive pulmonary disease (7), lung cancer and heart disease.

Resident # 14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/16/17, coded Resident # 14 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one staff member for activities of daily living.

An observation conducted on 06/06/17 at 3:30 p.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed.

An observation conducted on 06/06/17 at 6:15 p.m. revealed Resident # 14 was lying on his bed. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed.

An observation conducted on 06/07/17 at 7:30

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a.m. revealed Resident # 14 was lying on his bed sleeping. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed.

An observation conducted on 06/07/17 at 1:25 p.m. revealed Resident # 14 was lying on his bed napping. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed.

An observation conducted on 06/08/17 at 8:10 a.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed. CNA (certified nursing assistant) # 11 was observed entering Resident # 14's room with a breakfast tray. Resident # 14 then sat up on the edge of his bed and CNA # 11 placed the breakfast tray on the bedside table and set up the meal for Resident # 14.

The POS (physician order sheet) dated 06/01/2017 - 06/30/2017 for Resident # 14 documented, "Start Date: 03/23/2017. Fall Matt to Residents [sic] left side of bed and keep bed in low position due to falls. Every shift; day, evening, night."

The care plan for Resident # 14 dated 01/18/2016 documented, "Problem. Category: Falls. Resident is at risk for falls r/t (related to) his history of frequent falls, impaired mobility, use of psychoactive meds (medications), generalized weakness, is prescribed antihypertensive meds (medications), need for assistance with mobility tasks. He has demonstrated poor safety judgement in the past and has sensory

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impairment of his feet - paresthesias (8)." Under "Approach" it documented, "Approach Start Date: 01/21/2016. Fall mat to left side of bed and keep bed in low position as he will allow when resident is in bed and not attended by staff. Edited 06/08/2016."

The facility's "Progress Notes" for Resident # 14 dated 06/06/17 and 06/07/17 failed to evidence any documentation of Resident # 14 refusing the fall mat.

On 06/07/17 at 10:15 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager. When asked to describe the purpose of the care plan, LPN # 3 stated, "It shows the issues, problems, behaviors, long and short term goals and interventions." When asked if an intervention, procedure or treatment that is documented on the care plan should be implemented, LPN # 3 stated, "Yes." After reviewing the care plan for Resident # 14, LPN # 3 was asked if a fall mat should be in place for Resident # 14. LPN # 3 stated, "Yes." When made aware of the above observations of Resident #14 without a fall mat in place and asked if Resident # 14's care plan was being followed, LPN # 3 stated, "No."

On 06/07/17 an interview was conducted at 3:05 p.m. with Resident # 14. When asked if he had ever had a fall mat next to his bed Resident # 14 stated, "Not that I know of." Resident # 14 could not recall having a fall mat.

On 06/08/17 at approximately 12:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

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No further information was provided prior to exit.

References:

(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include watery diarrhea (at least three bowel movements per day for two or more days), fever, loss of appetite, nausea, abdominal pain or tenderness. You might get C. difficile disease if you have an illness that requires prolonged use of antibiotics. Increasingly, the disease can also be spread in the hospital. The elderly are also at risk. Treatment is with antibiotics. This information was obtained from the website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm.

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F 282	Continued From page 51 (6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (7) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (8) Numbness and tingling are abnormal sensations that can occur anywhere in your body, but they are often felt in your fingers, hands, feet, arms, or legs. This information was obtained from the website: https://medlineplus.gov/ency/article/003206.htm.	F 282		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309		7/19/17

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F 309	Continued From page 52 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: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide services to maintain the highest level of physicial well-being for four of 28 residents in the survey sample, Resident #6, Resident #2, Resident #20 and Resident #22. 1. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 6. 2. The facility staff failed to administer Clondine (a medication for high blood pressure) to Resident #2 on 6/3/17 per the physician order. 3. The facility staff failed to administer the correct physician prescribed dose of a cranberry capsule to Resident #20.	F 309	F309 Provide Care/Services for the highest Wellbeing-Quality of Life, Quality of Care and Pain Management 1) Non-pharmacological interventions and documentation were implemented for resident #6 on the MAR. Nursing staff educated on the use and documentation of non-pharmacologic interventions per the care plan. For resident #2 the physician was made aware that the nurse failed to give the Clonidine as ordered on 6/7/17 and an order to discontinue was received. The licensed nurse was educated to contact the physician for clarification of an order that seems excessive before holding the medication. The physician was contacted regarding resident #20 and the order for cranberry capsules was changed to the available house stock dosage of 425mg. The	

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F 309	Continued From page 53 4. The facility staff failed to administer medication to Resident #22 on 5/25/17 per the physician orders. The findings include: 1. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 6. Resident # 6 was admitted to the facility on 04/20/17 with diagnoses that included but were not limited to: lung cancer, diabetes mellitus (1), history of breast cancer, hypertension (2), gastroesophageal reflux disease (3), pain and fibromyalgia (4). Resident # 6's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/27/17, coded Resident # 6 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 6 was coded as requiring extensive assistance of one staff member for activities of daily living. The POS (Physician's Order Sheet) for Resident # 6 dated 06/01/2017 - 06/07/2017 documented, "Start Date: 04/26/2017. Oxycodone (5) - tablet; 5 (five) MG (milligrams): 1 (one) tablet; oral (by mouth). Special instructions: PRN (as needed) for Moderate - Severe pain. Every 4 (four) hours." The care plan for Resident # 6 dated 04/20/2017	F 309	Licensed Nursing staff was provided education on medication administration consistent with professional standard of practice. The physician was made aware that resident #22 did not receive Atorvastatin as ordered on the evening of admission, no new orders were given. The nurse was educated to check the stat box for medications that have not arrived from pharmacy. 2) All residents receiving prn pain medication, all residents receiving PRN blood pressure medication, all residents receiving house stock cranberry capsules and all new admissions with medications due the day of admission have the potential to be affected by the practice. A 100% audit of all residents receiving prn pain medication will be completed to ensure they have non-pharmacological documentation on the MAR. A 100% audit on all residents receiving the house stock cranberry capsules will be completed and clarifications will be obtained immediately. A list of medications available in the stat box will be provided to all nursing staff. A 100% audit of all PRN Blood Pressure (BP) medications will be completed to ensure compliance with parameters with all active residents. 3) Licensed nurses will be educated to administer medications in accordance with nursing principles and practices. Medications are administered in accordance with the written order of the physician. If a dose seems excessive considering the resident□s age and condition the nurse should call the	

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F 309	Continued From page 54 documented, "Problem: Category - Pain. Alteration in comfort due to fibromyalgia, lung cancer, djd (degenerative joint disease) and gallstones." Under "Approach" it documented, "Approach Start Date: 04/20/2017. Attempt non-pharmacological approaches. Document attempts and effectiveness. Edited: 05/09/2017." The eMAR (electronic medication administration record) for Resident # 6 dated 05/01/2017 - 05/31/2017 documented, "Oxycodone - tablet; 5 MG. Amount to Administer: 1 (one) tablet; oral." The eMAR dated 05/01/2017 - 05/31/2017 documented Oxycodone tablet; 5 MG was administered on the following dates and times: 05/01/17 at 4:45 a.m. and at 9:53 a.m., 05/02/17 at 5:04 a.m. and at 10:02 a.m., 05/03/17 at 4:57 a.m., 05/04/17 at 9:20 a.m., 05/05/17 at 5:01 a.m. and at 2:23 p.m., 05/06/17 at 5:06 a.m., 05/07/17 at 4:57 a.m., 05/08/17 at 5:11 a.m., 05/09/17 at 4:50 a.m., 05/10/17 at 5:02 a.m., 05/11/17 at 5:45 a.m., 05/12/17 at 9:27 a.m. and at 6:24 p.m., 05/14/17 at 8:35 a.m., 05/15/17 at 9:20 a.m., 05/16/17 at 9:30 a.m., 05/18/17 at 9:27 a.m., 05/19/17 at 4:59 a.m., 05/20/17 at 4:48 a.m. and at 9:40 a.m., 05/21/17 at 2:54 a.m., 05/24/17 at 1:05 p.m., 05/26/17 at 8:40 p.m., 05/27/17 at 7:20 a.m. and at 2:48 p.m., 05/29/17 at 8:49 p.m., and on 05/30/17 at 8:26 a.m. The eMAR coded for each date the Oxycodone 5 MG tablet was administered documented, "E (effective)." The eMAR dated 05/01/2017 - 05/31/2017 failed to evidence documentation of non-pharmacological approaches. The facility's "Progress Notes" for Resident # 6 dated 05/01/2017 - 05/31/2017 failed to evidence	F 309	provider and/or pharmacy prior to administration. The interaction with the pharmacy and the resulting order clarification are then documented in the medical record as appropriate. a. All new admissions and all new physician orders will be reviewed daily in clinical meeting to ensure continued compliance. Any deviations or omissions will be corrected, logged and reported weekly to the DON. b. A monthly audit of PRN BP orders will be done to ensure compliance with parameters on all residents. c. DON or designee will complete a monthly audit on new OTC cranberry capsule medication orders to ensure facility supply dose matches the physician order 4) Results of the audits will be brought to the Q.A. committee meeting for review and recommendations.	

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documentation of non-pharmacological approaches.

On 06/07/17 at 10:15 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager. When asked to describe the procedure of administering PRN pain medication, LPN # 3 stated, "Assess the resident's pain using a pain scale 1 (one) to 10, with 10 being the worse pain, and the location of the pain. If the resident is nonverbal use the resident's facial expressions. Try non-pharmacological interventions before administering the pain medication every time. Document the interventions on the MAR. If the non-pharmacological interventions don't work give the pain medication and reassess the resident's pain after about one hour." After reviewing the eMAR dated 05/01/2017 - 05/31/2017 and the progress notes dated 05/01/2017 through 05/31/2017 for Resident # 6, LPN # 3 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 3 stated, "No, it wasn't done."

On 06/07/17 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) # 17. When asked to describe the procedure of administering PRN pain medication, LPN # 17 stated, "Assess the resident's pain, ask where the pain is, the type and use a pain scale 1 (one) to 10, with 10 being the worse pain. If the resident is nonverbal use the resident's facial expressions. Try non-pharmacological interventions before administering the pain medication every time. Document the interventions on the MAR. If the non-pharmacological interventions don't work give the pain medication and reassess the

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resident's pain after about one hour." After reviewing the eMAR dated 05/01/2017 - 05/31/2017 and the progress notes dated 05/01/2017 through 05/31/2017 for Resident # 6, LPN # 17 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 17 stated, "I don't see any documentation of non-pharmacological interventions. I can't say it was done."

The facility's policy "Pain Assessment" documented, "6. Document the presence of pain showing present and past interventions utilized by the resident for pain relief. This could include: pain medications (prescription and OTC [over the counter]); alternative treatments such as repositioning, back rubs, heat and cold applications."

On 06/07/17 at approximately 5:40 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) A common syndrome in which a person has long-term pain that is spread throughout the body. The pain is most often linked to fatigue, sleep problems, headaches, depression, and anxiety. People with fibromyalgia may also have tenderness in the joints, muscles, tendons, and other soft tissues. This information was obtained from the website: https: https://medlineplus.gov/ency/article/000427.htm.

(5) Oxycodone is used to relieve moderate to severe pain. Oxycodone extended-release tablets and extended-release capsules are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682132.html.

2. The facility staff failed to administer Clonidine (a medication for high blood pressure) to Resident #2 on 6/3/17 per the physician order.

Resident #2 was admitted to the facility on 11/15/16 and readmitted on 5/313/17, with diagnoses that included but were not limited to: stroke, muscle weakness, high blood pressure, chronic kidney disease, diabetes, hepatitis C, history of alcohol and drug abuse, and pain. The

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resident recently had an AV (arterial venous) shunt placed in preparation for dialysis (a medical procedure for filtering waste products from the blood of some kidney-disease patients or for removing poisons or drugs (1)).

The most recent MDS (Minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/13/17, coded the resident as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of his activities of daily living except eating in which he was coded as requiring supervision after set up assistance was provided.

A physician order dated, 5/31/17 documented, "Clonidine HCL (hydrochloride) (used to treat high blood pressure (2)) 0.1 mg (milligrams), amt (amount) 1 tab (tablet) oral; Special Instructions: IF SBP (systolic blood pressure) greater than 170 or DBP (diastolic blood pressure) greater than 90, every 6 hours PRN (as needed)."

The June 2017 MAR (medication administration record) documented, "Clonidine HCL 0.1 mg, amt 1 tab oral; Special Instructions: IF SBP greater than 170 or DBP greater than 90, every 6 hours PRN." The medication was not administered in June 2017.

Review of the clinical record revealed the following blood pressure reading documented in the clinical record on 6/3/17 @ 7:16 a.m. - 197/92. There was no nurse's note on 6/3/17 related to the blood pressure.

The comprehensive care plan dated, 11/30/17,

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documented in part, "Problem: Cardiovascular System, need for observation r/t (related to) Dx (diagnosis); Hypertension (high blood pressure) & Hyperlipidemia (too high fats in the bloodstream)." The "Approach dated, 11/30/16, documented in part, "Vital Signs as ordered and as indicated."

An interview was conducted with LPN (licensed practical nurse) #15 on 6/7/17 at 1:15 p.m. LPN #15 was asked to review the above physician order for Clonidine. When asked what she would do with this Clonidine order, LPN #15 stated, "Well, if the blood pressure was high when I took it, then I would have the option to give it (Clonidine)." When asked if she should take the blood pressure every six hours, LPN #15 stated, "No, it's a PRN medication. I would look for any symptoms of high blood pressure as needed. It's a PRN; I would not routinely take his blood pressure every six hours, only if he had symptoms." Resident #2's blood pressure of 197/92 on 6/3/17 at 7:16 a.m. was reviewed with LPN #15, and LPN #15 was then asked if the Clonidine should have been given for this blood pressure reading per the physician orders, LPN #15 stated, "He was due for his routine blood pressure medications. I gave his normal medications. I didn't think to give the PRN as he was getting his normal medications."

An interview was conducted with RN (registered nurse) #3, the unit manager; on 6/7/17 at 1:23 p.m. RN #3 was asked to review Resident #2's order for Clonidine and the blood pressure reading for 6/3/17. RN #3 stated, "Based on the physician order, the nurse should have administered the medication."

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Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate QA (quality assurance) clinical nurse consultant, and ASM #4, the assistant director of nursing, were made aware of the above findings on 6/7/17 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 164.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details
3. The facility staff failed to administer the correct physician prescribed dose of a cranberry capsule to Resident #20.

Resident #20 was admitted to the facility on 7/1/16. Resident #20's diagnoses included but were not limited to: pneumonia, urinary tract infection and high blood pressure. Resident #20's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/17, coded the resident as cognitively intact.

Review of Resident #20's clinical record revealed a physician's order dated 2/15/17 for an over the counter cranberry capsule- 400 mg (milligrams) twice a day. Resident #20's June 2017 MAR (medication administration record) documented an order for a cranberry capsule- 400 mg twice a day. Resident #20's comprehensive care plan revised on 5/26/17 failed to document information regarding the cranberry capsule.

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A MAR note dated 6/5/17 documented Resident #20's cranberry capsule was not administered because the item was not available.

On 6/8/17 at 9:48 a.m., observation of the over the counter medications in the facility central supply was conducted with OSM (other staff member) #8 (the central supply employee). Cranberry capsules- 425 mg were observed. OSM #8 stated she could only order that dose of cranberry capsules.

On 6/8/17 at 10:00 a.m. this surveyor asked ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality assurance clinical nurse consultant) to provide the pharmacy manifest for Resident #20's cranberry capsule to evidence when the capsule was delivered to the facility.

On 6/8/17 at 12:35 p.m. LPN (licensed practical nurse) #8 stated there was no pharmacy manifest for Resident #20's cranberry capsule because the capsule was obtained from the bulk medications in the facility central supply. LPN #8 was made aware the cranberry capsules available in central supply were 425 mg capsules and Resident #20's physician order was for 400 mg capsules. LPN #8 was asked if Resident #20 had been receiving 425 mg capsules. LPN #8 stated she would say the 425 mg capsules were the capsules pulled from central supply and the order needed to be clarified.

On 6/8/17 at 12:40 p.m. the medication cart containing Resident #20's medications was observed by this surveyor and LPN #4. LPN #4 was asked to show this surveyor Resident #20's cranberry capsules. LPN #4 pulled out a bottle of

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cranberry capsules that were 425 mg. LPN #4 confirmed Resident #20 had been administered the 425 mg capsules although the physician's order was for 400 mg. LPN #4 stated she was waiting for clarification from the physician. LPN #4 was asked the facility process to ensure medications are administered per physician's orders. LPN #4 stated she checks the MAR and checks the bottle containing the cranberry capsules. LPN #4 was asked what should be done if the dose on the bottle doesn't match the dose written on the MAR. LPN #4 stated she should obtain clarification from the physician. LPN #4 stated she didn't notice there was a difference in the dose of the cranberry capsule prescribed by the physician and the dose that was contained in the bottle.

On 6/8/17 at 1:10 p.m., ASM (administrative staff member) #1 and ASM #3 were made aware of the above findings and asked what standard of practice the facility staff follows regarding order clarification and medication administration. ASM #3 stated staff follows the facility policies.

The facility policy titled, "MEDICATION ADMINISTRATION- General Policies and Procedures" documented, "C. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule..."

No further information was presented prior to exit.

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(1) Cranberry capsules are prescribed for the prevention of urinary tract infections. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/25180378

4. The facility staff failed to administer medication to Resident #22 on 5/25/17 per the physician orders.

Resident #22 was admitted to the facility on 5/25/17. Resident #22's diagnoses included but were not limited to: heart disease, high blood pressure and generalized anxiety disorder. Resident #22's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 6/1/17, coded the resident's cognition as moderately impaired.

Review of Resident #22's clinical record revealed a nurse's note dated 5/25/17 that documented the resident was admitted to the facility on that day at 4:00 p.m.

Resident #22's admission physician's orders dated 5/25/17 documented an order for atorvastatin (1) 20 mg (milligrams) once a day at 9:00 p.m.

Resident #22's May 2017 MAR (medication administration record) documented atorvastatin 20 mg was not administered on 5/25/17 at 9:00 p.m. The MAR notes documented, "Not Administered: On Hold. Comment: give as soon as in from pharmacy." The MAR and nurses' notes for 5/25/17 failed to document the medication was given that night.

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Review of the facility STAT box list revealed atorvastatin was available in the STAT box (a box containing various medications).

Resident #22's comprehensive care plan revised on 5/31/17 documented, "Resident requires a therapeutic diet to address heart disease...Administer medications as prescribed...'

The nurse responsible for administering 9:00 p.m. medications to Resident #22 on 5/25/17 was not available for interview.

On 6/8/17 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if the facility had a process to ensure medications for a newly admitted resident arrived to the facility in a timely manner. LPN #3 stated when a new resident is admitted he faxes the resident's face sheet to the pharmacy, lets the physician approve the medications and enters the medications into the computer system that goes to the pharmacy. LPN #3 stated if a medication is needed then he obtains the medication from the STAT box or he calls the pharmacy. LPN #3 was asked if 9:00 p.m. medications should be available for a resident who is admitted at 4:00 p.m. on the same day. LPN #3 stated, "Yes. You should figure out a way to get it."

On 6/8/17 at 10:00 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality assurance clinical nurse consultant) were made aware of the above concern.

The facility policy titled, "Emergency Supply Kits" documented, "POLICY: Emergency pharmaceutical service is available on a 24-hour

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F 309	Continued From page 65 basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the contracted pharmacy..." No further information was presented prior to exit. (1) Atorvastatin is used to treat high cholesterol. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=786a6f14-1e2d-4c2a-93dd-c45315aff4fd	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide wound care in a manner to prevent	F 314	F314 Treatment/Services to Prevent/Heal Pressure sores 1) Wound care was immediately re-done on resident #5 and #1. The licensed	7/19/17

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F 314	Continued From page 66 infection and promote healing for two of 28 residents, Resident #'s 5 and 1. 1. During wound care provided to Resident #5, LPN (licensed practical nurse) #11 failed to maintain a clean surface for wound dressings, failed to wash her hands prior to, during and after the dressing change and failed to clean scissors prior to use. 2. The facility staff failed to clean scissors prior to providing wound care for Resident #1's pressure injury. The findings include: 1. During wound care provided to Resident #5, LPN (licensed practical nurse) #11 failed to maintain a clean surface for wound dressings, failed to wash her hands prior to and during the dressing change and failed to clean scissors prior to use. Resident #5 was admitted to the facility on 1/28/16 with diagnoses that included, but were not limited to, anoxic brain damage (caused by a period of time without oxygen), dysphagia (difficulty with swallowing), aphasia (difficulty with speaking), disease of the heart, diabetes, high level of lipids in the blood stream and osteomyelitis (an infection of the bone). Resident #5's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 5/1/17. Resident #5 was coded as being unable to complete the interview for Section C, BIMS (brief interview for mental status), a staff assessment was completed and coded Resident #5 as a 3 (three),	F 314	nursing staff involved was educated immediately on proper wound care procedures, hand hygiene and cleaning scissors with alcohol before and after use. 2) All residents who had wound care provided by staff # (6) and (11) have the potential to be affected by the same practice. The DON or designee will conduct a 100% observational audit of all residents who receive wound care from staff # (6) and (11), and any similar issues were addressed immediately. 3) The licensed nursing staff were provided education on: a. Wound care consistent with professional standards of practice b. Hand Hygiene during wound care c. Cleaning scissors with alcohol before and after use. d. The DON or designee will complete a 25% weekly audit of current residents receiving wound care for completion of the wound care treatment consistent with professional standards of practice to promote healing, prevent infection, prevent new ulcers from developing, and to ensure ongoing compliance with practice. If deficient practice is observed during observational audit, then that nurse will be educated and another observation of the same nurse will be repeated to ensure compliance. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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indicating that Resident #5 is severely cognitively impaired with daily decision making.

A review of Resident #5's clinical record revealed, in part, a nurse's note dated 5/3/17 documenting two pressure ulcers on Resident #5's left foot second toe. A treatment was put into place and Resident #5 was seen by the wound nurse on 5/5/17 and then by a wound care physician on 5/9/17.

A review of Resident #5's clinical record revealed, a wound care specialist evaluation dated 6/6/17, that documented, in part, the following: "Unstageable (1) (Due to Necrosis) of the left, dorsal (back), posterior (behind), second toe. Stage 3 (three) Pressure Wound of the left, dorsal, anterior (front), second toe." Treatments were in place.

A review of Resident #5's comprehensive care plan dated 5/31/17 revealed, in part, the following documentation; "Problem: Problem start date: 5/5/17. Resident Currently has Pressure ulcer to L (left) 2nd toe and is at risk for further skin breakdown. Edited: 5/31/2017. Goal: Short Term Goal Target Date: 8/16/2017. Pressure ulcer will show evidence of healing and will be free of signs and symptoms of infection by next review. Edited: 5/16/2017." There were no directives regarding daily wound care.

On 6/7/17 at 2:40 p.m. a wound care observation was conducted. LPN (licensed practical nurse) #11 was observed providing wound care to Resident #5's left second toe pressure ulcers. Resident #5 remained seated in a geri-chair in a reclined position beside his bed. LPN #11 drew the privacy curtain around Resident #5. LPN #11

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explained that Resident #5's foot was contracted and it was often difficult to extend his leg outward to be able to get to the toes on the left foot. LPN #11 extended Resident #5's left heel to rest on the foot rest. LPN #11 gathered her supplies; 4 x 4 gauze, a kerlix bandage, a foam bandage, tape measure and normal saline bullets. LPN #11 laid all the supplies on top of Resident #5's bed, the gauze was in direct contact with the blanket over the bed. LPN #11 positioned Resident #5 and then picked up all the supplies and placed them on a bedside table. The table had not been wiped down and a protective pad was not placed over the table. LPN #11 was not observed washing her hands, but did put on gloves. LPN #11 then removed scissors from her pocket and proceeded to remove Resident #5's sock from his left foot; the sock was laid on the floor. LPN #11 then cut away the old bandage dressing with the scissors removed from her pocket. LPN # 11 then returned the scissors to her pocket and threw the old bandage into the trash can beside Resident #5's bed. Resident #5's toes were observed contracted under the foot and the wounds were dry, without exudate. LPN #11 took the 4 x 4 gauze from the table held the gauze directly beneath the wound areas on the toe and retrieved a normal saline bullet, and squirted normal saline directly into the wound, catching the excess normal saline in the gauze pad. At this time this writer asked LPN #11 to obtain measurements of the wound. LPN #11 reached onto the table to retrieve her tape measure from the table and placed it directly onto the wounds to obtain measurements. LPN #11 stated that there was only one wound as both wounds had joined. A measurement was obtained as 2.5 cm (centimeters) x 1.7 cm x (unable to obtain depth). Once the measurement was completed, LPN #11

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threw away the tape measure and gauze pads into the bedside trash can and then applied hydrogel (2), directly to the wound. LPN #11 retrieved the foam dressing from the table and applied the foam dressing to the wound; she then retrieved the kerlix bandage from the table and wrapped Resident #5's foot. Once the bandage had been applied, LPN #11 retrieved the sock from the floor and placed it back on Resident #5's foot. At no time during this wound care process was LPN #11 observed washing her hands and/or applying hand sanitizer. LPN #11 was also not observed changing her gloves.

LPN #11 exited the room and was interviewed at the treatment cart about the wound treatment process above. LPN #11 was asked whether or not she provided a clean area for her supplies. LPN #11 stated, "No I didn't, and I don't know why I didn't do that, I just didn't." When asked about the use of the bedside table, LPN #11 stated that she did not clean the table before starting and should have. LPN #11 was asked why it was important to provide a clean area for the supplies, LPN #11 stated, "To prevent infection." LPN #11 was asked about cleaning her scissors. LPN #11 stated that she had cleaned them at the beginning of the shift. LPN #11 was asked where she kept her scissors, LPN #11 stated, "In my pocket." LPN #11 was asked if her pocket was clean, LPN #11 stated, "No, not really I keep my keys and marker in there too." LPN #11 was asked about when she measured the wound, LPN #11 stated, "I know, I should have re-cleaned the wound after placing the tape measure against the wound." LPN #11 was asked why she should have done that, LPN #11 stated, "I contaminated the wound." LPN #11 was asked about hand washing, LPN #11 stated

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that she should have washed her hands between removing the soiled dressing and applying the new dressing. When asked if she had done that LPN #11 stated that she had not.

An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time. A policy was request regarding wound care and dressing changes.

A review of the facility policy "Dressing Change (Clean)" revealed, in part, the following documentation; "Purpose: To protect a wound; to prevent infection and / or spread of infection; and to promote healing. Procedure: 3. Wash hands. 5. Place plastic bag near the foot of the bed to receive the soiled dressing. 6. Create the clean field with paper towels or disposable drape. 8. Put on the first pair of gloves. 9. Remove soiled dressing and discard in a plastic bag. 10. Dispose of gloves in the plastic bag. 11. Wash hands and put on the clean pair of gloves. 16. Remove gloves and discard with all unused supplies in plastic bag. 17. Wash hands."

A review of the facility policy "Infection Control - Hand Hygiene" revealed, in part, the following documentation; "POLICY: Facility staff follow hand hygiene procedures to improve hand hygiene practices and reduce transmission of pathogenic microorganisms to residents and personnel in the facility. Hand Hygiene is required: d. After contact with body fluids or

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excretions, mucous membranes, non-intact skin, and wound dressings even if hands are not visibly soiled."

On 6/8/17 at 10:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked about the wound care and the process for conducting wound care. ASM #2 stated, "Review the order, gather supplies and use appropriate infection control practices." ASM #2 was asked to elaborate on the infection control practices as it pertained to wound care. ASM #2 stated, "Hand washing, maintain a clean environment when conducting wound care." ASM #2 further stated that the facility was going to re-educate all the nursing staff.

No further information was provided prior to the end of the survey process.

(1) Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.
(2) http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.

A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear

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may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blancheable erythema of intact skin
Intact skin with a localized area of non-blancheable erythema, which may appear differently in darkly pigmented skin. Presence of blancheable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

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
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;

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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.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

This information was obtained from the following website:
http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

(2) Hydrogel dressings consist of 90 percent water in a gel base, according to the medical journal Apple Bites, and serves to help monitor

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fluid exchange from within the wound surface. By keeping the wound moist, the hydrogel dressing assists in protecting your body from wound infection and promotes efficient healing. This information was obtained from the following website;
https://www.advancedtissue.com/use-hydrogel-wound-care/
2. The facility staff failed to clean scissors prior to providing wound care for Resident #1's pressure injury.

Resident #1 was admitted to the facility on 10/14/10. Resident #1's diagnoses included but were not limited to: chronic kidney disease, major depressive disorder and anxiety disorder. Resident #1's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/15/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #1's clinical record revealed the resident presented with an unstageable pressure injury (1) on the left upper calf. Resident #1's comprehensive care plan revised on 5/31/17 documented, "new opened area on back of left lower extremity...treatment as ordered..."

On 6/7/17 at 11:05 a.m. this surveyor observed LPN (licensed practical nurse) #6 provide wound care for Resident #1. LPN #6 pulled scissors and a Sharpie marker out of her pocket. LPN #6 failed to clean the scissors before using them to cut a dressing that was placed on Resident #1's wound. Immediately after wound care an interview was conducted with LPN #6. LPN #6 was asked what other objects were in her pocket.

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LPN #6 stated she had a set of keys in her pocket. LPN #6 was made aware of this surveyor's observation. LPN #6 stated she cleaned her scissors with bleach after she provided wound care to the previous resident. LPN #6 was made aware the scissors were in her pocket with a marker and a set of keys. LPN #6 confirmed she should have cleaned the scissors after she removed them from her pocket.

On 6/7/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the corporate quality assurance clinical nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings.

The facility policy titled, "DRESSING CHANGE (CLEAN)" documented, "PURPOSE: To protect a wound; to prevent irritation; to prevent infection and/or spread of infection; and to promote healing. JUSTIFICATION: Many times when a dressing is to be changed or applied, sterile dressings are not needed. The use of clean technique and clean dressings will provide the adequate treatment coverage to enhance healing while preventing and treating infections..."

In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick.
In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and

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gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol.
Reference:
Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000

No further information was provided prior to exit.

(1) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed..." This information was obtained from the website:

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F 314	Continued From page 77 http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and complaint investigation, it was determined that the facility staff failed to implement a physician ordered safety device for one of 28 residents in the survey sample, Resident # 14.	F 323	F323 Implement Safety 1) The Bedside mat order for resident # 14 was discontinued as a current approach and was removed from the care plan. Licensed Nursing staff # (11) was educated on timely updating of	7/19/17

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F 323	Continued From page 78 The facility staff failed to put a fall mat next to the Resident # 14's bed according to the physician's order. The findings include: Resident # 14 was readmitted to the facility on 03/23/16 with diagnoses that included but were not limited to: atrial fibrillation (1), gastroesophageal reflux disease (2), clostridium difficile [C. difficile] (3), diabetes mellitus (4), schizophrenia (5), hypertension (6), chronic obstructive pulmonary disease (7), lung cancer and heart disease. Resident # 14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/16/17, coded Resident # 14 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one staff member for activities of daily living. An observation conducted on 06/06/17 at 3:30 p.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed. An observation conducted on 06/06/17 at 6:15 p.m. revealed Resident # 14 was lying on his bed. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed. An observation conducted on 06/07/17 at 7:30	F 323	approaches on the care plan per facility policy. 2) All residents who have current orders for bedside mats have the potential to be affected by the same practice. The Director of Nursing or designee will complete a 100% audit of all current residents who have orders or discontinued orders for bedside mats to ensure their care plan reflects current orders in the past 90 days. Any similar issues will be addressed immediately. 3) The Licensed Nursing staff were educated on: a. Timely updating of the Care Plan approaches per facility policy. The Director of Nursing or designee will complete a monthly audit x 3 months of all residents with bedside mats or discontinued bedside mats within the last 30 days to ensure ongoing compliance with care plan updates and all orders to discontinue bedside mats will be reviewed in clinical meeting daily with an appropriate care plan update. 4) Results of the audit are presented to Quality Assurance committee for review and recommendations.	

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a.m. revealed Resident # 14 was lying on his bed sleeping. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed.

An observation conducted on 06/07/17 at 1:25 p.m. revealed Resident # 14 was lying on his bed napping. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed.

An observation conducted on 06/08/17 at 8:10 a.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room failed to evidence a fall mat on the floor next to Resident # 14's bed. CNA (certified nursing assistant) # 11 was observed entering Resident # 14's room with a breakfast tray. Resident # 14 then sat up on the edge of his bed and CNA # 11 placed the breakfast tray on the bedside table and set up the meal for Resident # 14.

The POS (physician order sheet) dated 06/01/2017 - 06/30/2017 for Resident # 14 documented, "Start Date: 03/23/2017. Fall Matt to Residents [sic] left side of bed and keep bed in low position due to falls. Every shift; day, evening, night."

The care plan for Resident # 14 dated 01/18/2016 documented, "Problem. Category: Falls. Resident is at risk for falls r/t (related to) his history of frequent falls, impaired mobility, use of psychoactive meds (medications), generalized weakness, is prescribed antihypertensive meds, need for assistance with mobility tasks. He has demonstrated poor safety judgement in the past and has sensory impairment of his feet -

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paresthesias (8)." Under "Approach" it documented, "Approach Start Date: 01/21/2016. Fall mat to left side of bed and keep bed in low position as he will allow when resident is in bed and not attended by staff. Edited 06/08/2016."

The eTAR (electronic treatment administration record) for Resident # 14 dated 06/01/2017-06/08/2017 documented, "Fall Matt to Residents [sic] left side of bed and keep bed in low position due to falls." Further review of the eTAR revealed nurse's initials on 06/06/17 and 06/07/17 for the day, evening and night shifts. Further review of the eTAR failed to evidence any documentation of Resident # 14 refusing the fall mat.

The facility's "Progress Notes" for Resident # 14 dated 06/06/17 and 06/07/17 failed to evidence any documentation of Resident # 14 refusing the fall mat.

Review of the EHR (electronic health record) for Resident # 14 revealed the facility's "Event Report" dated 02/07/2017. The "Event Report" revealed Resident # 14 had a fall without injury on 02/07/2017. Review of Resident # 14's EHR revealed safety devices were in place prior to and following the fall on 02/07/2017. Further review of the EHR revealed Resident # 14 has not had a fall since 02/07/2017.

On 06/07/17 an interview was conducted at 3:05 p.m. with Resident # 14. When asked if he had ever had a fall mat next to his bed Resident # 14 stated, "Not that I know of." Resident # 14 could not recall having a fall mat.

On 06/08/17 at 8:15 a.m. an interview was

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conducted with CNA # 11. When asked if she had provided Resident # 14 with his breakfast, CNA # 11 stated, "Yes." When asked about Resident # 14's fall mat, CNA # 11 stated, "He doesn't have a fall mat."

On 06/08/17 at 8:20 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager. When asked about the fall mat for Resident # 14, LPN # 3 stated that he was not aware of a physician's order for a fall mat. When asked how the CNAs know what safety or adaptive devices a resident requires, LPN # 3 stated, "The CNAs have the information on the computerized charting screen under the ADL (activities of daily living) check list." After reviewing the ADL charting check list for Resident # 14, LPN # 3 and CNA # 11 were asked if a fall mat was listed for Resident # 14. LPN # 3 and CNA # 11 stated "No." LPN # 3 was then asked to review the POS dated 06/01/2017 - 06/30/2017 and the care plan dated 01/18/2016 for Resident # 14. After completing the review, LPN # 3 stated, "The resident should have a fall mat"

On 06/08/17 at 12:20 p.m. an interview was conducted with LPN # 17. After reviewing the eTAR for Resident # 14 dated 06/06/2017-06/07/2017, LPN # 17 was asked if she signed her initials on 06/07/17 for the day shift indicating the fall mat was in place for Resident # 14. LPN # 17 stated, "Yes." When asked if she had seen the fall mat on the floor next to the Resident # 14"s bed, LPN # 17 stated, "I don't remember if it was there." When informed that this surveyor had two observations during her shift on the seventh of June and did not observe the fall mat on the floor next to the resident's bed or anywhere in the resident's room,

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LPN # 17 had no response.

On 06/08/17 at approximately 12:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

Complaint Deficiency

References:

(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include watery diarrhea (at least three bowel movements per day for two or more days), fever, loss of appetite, nausea, abdominal pain or tenderness. You might get C. difficile disease if you have an illness that requires prolonged use of antibiotics. Increasingly, the disease can also be spread in the hospital. The elderly are also at risk. Treatment is with antibiotics. This information was obtained from the website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This

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F 323	Continued From page 83 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (5) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (7) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (8) Numbness and tingling are abnormal sensations that can occur anywhere in your body, but they are often felt in your fingers, hands, feet, arms, or legs. This information was obtained from the website: https://medlineplus.gov/ency/article/003206.htm.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	F 328		7/19/17

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(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a

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F 328	Continued From page 85 resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to ensure oxygen equipment was stored in a sanitary manner for one of 28 residents in the survey sample, Resident # 14. The facility staff failed to keep Resident # 14's oxygen nasal cannula (a device for delivering oxygen by way of two small tubes that are inserted into the nares (1)) and nebulizer (2) mask covered when not in use. The findings include: Resident # 14 was readmitted to the facility on 03/23/16 with diagnoses that included but were not limited to: atrial fibrillation (3), gastroesophageal reflux disease (4), clostridium difficile [C. difficile] (5), diabetes mellitus (6), schizophrenia (7), hypertension (8), chronic obstructive pulmonary disease (9), lung cancer and heart disease. Resident # 14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/16/17, coded Resident # 14 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one	F 328	F328 Oxygen Storage 1/28 Residents 1) The Nebulizer mask and O2 cannula for resident # 14 was replaced and stored properly at bedside. The Licensed nursing staff # 3 was provided education on proper storage of nebulizer mask and O2 cannula while not in use. 2) All residents who utilize nebulizer masks and O2 cannulas have the potential to be affected by the same practice. The Director of Nursing or designee will complete a 100% audit of all residents who utilize nebulizers and O2 cannulas as part of their plan of care for proper storage of equipment at bedside, any similar issues were addressed immediately. 3) The Licensed Nursing staff were provided education on: a. Proper storage of nebulizer equipment and O2 cannulas at bedside. The Director of Nursing or designee will accomplish a weekly audit of 25% of the residents who utilize nebulizer therapy and O2 cannulas to ensure ongoing compliance with this practice. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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staff member for activities of daily living.

An observation conducted on 06/06/17 at 11:35 a.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room revealed Resident #14's nebulizer mask sitting on the bedside table uncovered. Also the resident's nasal cannula attached to the oxygen tubing was hanging over the back of the oxygen concentrator and was uncovered.

An observation conducted on 06/06/17 at 3:30 p.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room revealed the residents nebulizer mask sitting on the bedside table uncovered. Resident #14's nasal cannula attached to the oxygen tubing was hanging over the back of the oxygen concentrator and was uncovered.

An observation conducted on 06/06/17 at 6:15 p.m. revealed Resident # 14 was lying on his bed. Further review of the resident's room revealed the residents nebulizer mask sitting on the bedside table uncovered and the nasal cannula attached to the oxygen tubing was hanging over the back of the oxygen concentrator uncovered.

An observation conducted on 06/07/17 at 7:30 a.m. revealed Resident # 14 was lying on his bed sleeping. Further review of the resident's room revealed Resident #14's nebulizer mask was hanging off the left side of the bed uncovered and the resident's nasal cannula attached to the oxygen tubing was hanging over the back of the oxygen concentrator uncovered.

An observation conducted on 06/07/17 at 1:25

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p.m. revealed Resident # 14 was lying on his bed napping. Further review of the resident's room revealed the residents nebulizer mask sitting on the bedside table uncovered. Resident #14's nasal cannula attached to the oxygen tubing was hanging over the back of the oxygen concentrator and was uncovered.

An observation conducted on 06/08/17 at 8:10 a.m. revealed Resident # 14 was lying on his bed watching television. Further review of the resident's room revealed the nebulizer mask sitting on the bedside table in a clear plastic bag. The bag had the following documented on it, "6/7/17; 11-7 (11:00 p.m. through 7:00 a.m.). Resident # 14 was receiving oxygen by the nasal cannula. The oxygen concentrator was set at two liters per minute and a clear plastic bag with "6/7/17; 11-7" documented on it was attached to the front of the oxygen concentrator.

The POS (physician order sheet) dated 06/01/2017 - 06/30/2017 for Resident # 14 documented, "Start Date: 03/23/2017. O2 (oxygen) 2 (two) LM (liters per minute) PRN (as needed) During the day. Twice a day" and "Ipratropium bromide solution; 0.02% (percent) 1 (one) vial inhalation. [Dx (diagnosis): chronic obstructive pulmonary disease]."

The care plan for Resident # 14 dated 01/18/2016 documented, "Problem. Resident is at risk for cardiopulmonary complications r/t (related to) lung cancer, COPD (chronic obstructive pulmonary disease)." Under "Approach" it documented, "Approach Start Date: 06/08/2016. Administer oxygen as ordered" and "Approach Start Date: 06/08/2016. Administer respiratory treatment as ordered."

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On 06/08/17 at 9:05 a.m. an observation of Resident # 14's room and interview was conducted with LPN (licensed practical nurse) # 3, unit manager. Upon entering Resident # 14's room the nasal cannula of the Resident # 14's oxygen concentrator was observed lying on the floor on the left side of Resident # 14's bed. LPN # 3 immediately picked up the nasal cannula and stated that it should not have been lying on the floor. When asked about the plastic bag containing the nebulizer mask dated 6/7/17, 11-7 and the plastic bag hanging on the oxygen concentrator dated 6/7/17, 11-7, LPN # 3 stated that the bags were put in place during the 11 to 7 shift last evening. When informed of the observations of the nebulizer mask and nasal cannula not being covered on 06/06/17 through 06/07/17, LPN # 3 stated, "They should have been in bags."

On 06/08/17 at approximately 12:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

References:
(1) This information was obtained from the website:
http://medical-dictionary.thefreedictionary.com/nasal+cannula

(2) Because you have asthma, COPD, or another lung disease, your doctor has prescribed medicine that you need to take using a nebulizer. A nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece.

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Medicine goes into your lungs as you take slow, deep breaths for 10 to 15 minutes. It is easy and pleasant to breathe the medicine into your lungs this way. This information was obtained from the website: https: https://medlineplus.gov/ency/patientinstructions/000006.htm.

(3) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) A bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include watery diarrhea (at least three bowel movements per day for two or more days), fever, loss of appetite, nausea, abdominal pain or tenderness. You might get C. difficile disease if you have an illness that requires prolonged use of antibiotics. Increasingly, the disease can also be spread in the hospital. The elderly are also at risk. Treatment is with antibiotics. This information was obtained from the website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.

(6) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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F 328	Continued From page 90 (7) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. (8) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (9) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 328		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to prevent a significant medication error for one of 28 residents in the survey sample, Resident #16. During medication administration observation a facility staff member was observed administering Resident #16, Furosemide (1), a diuretic, 80 mg (milligrams) and the physician order was for Furosemide 20 mg. Clinical documentation revealed that the pharmacy sent and staff documented they administered, Furosemide 80	F 333	F333 Resident free of significant med error 1) The physician and RP was contacted regarding Resident #16 and the incorrect dose of Lasix and Lasix 40mg BID is given per physician order. The Licensed Nursing staff was provided education on medication administration consistent with professional standard of practice. Pharmacy staff was reeducated on the proper implementation of medication orders originating from the facility's electronic health record (completed	7/19/17

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F 333	Continued From page 91 mg (milligrams) two times daily between 5/26/17 and 6/6/17 when the physician order was for Furosemide 20 mg two times daily. The findings include: Resident #16 was admitted to the facility on 12/10/16 with diagnoses that included, but were not limited to; chronic obstructive pulmonary disease, heart failure, diabetes, peripheral vascular disease and high blood pressure. Resident #16's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 3/15/17. Resident #16 was coded as scoring eight out of a possible 15 in Section C, Cognitive Patterns, BIMS (brief interview for mental status), indicating that Resident #16 is moderately cognitively impaired with daily decision making. Section N, Medications, codes Resident #16 as receiving a diuretic each day. During medication administration observation on 6/7/17 at 8:30 a.m. LPN (licensed practical nurse) #9 was observed administering Furosemide, a diuretic, 80 mg (milligrams). The medication was individually wrapped with a label and placed in a sealed bag, along with other medications to be administered on 6/7/17 at 9:00 a.m., and a list of the medications enclosed printed on the sealed bag. LPN #9 was observed comparing the list on the sealed bag with the electronic MAR. LPN #9 then opened the bag and removed the individually wrapped medications to be administered. LPN #9 then proceeded to compare the contents of the package with the list on the front of the package and the MAR. LPN #9 handed the package to this writer, the package documented	F 333	6/26/17). 2) All residents who receive medications from Remedi pharmacy have the potential to be affected by the same practice. The pharmacy will complete a 100% medication reconciliation audit, comparing current medication orders in the medical record with the medication dispensed from the pharmacy, by July 7, 2017. Any discrepancies will be reported immediately to the Director of Nursing to be reconciled. 3) A) The Licensed Nursing staff were educated on: 1. Medication administration consistent with professional standards of practice. 2. Checking dosage on Paxit bags and or medication packet compared to physician order on Medication administration record to ensure medication is given per the physician order. B) The pharmacy staff were educated on the proper implementation of medication orders originating from the facility's electronic health record (completed 6/26/17). C) Remedi Pharmacy will complete a 100% monthly reconciliation audit again in August and September of 2017 comparing current medication orders in the medical record with medication being dispensed from the pharmacy and any discrepancies will be immediately reported to the Director of Nursing to be reconciled. D) The DON or designee will perform a total of five medication pass observations weekly. This will be performed over all three shifts to ensure a variety of nurses	

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F 333	Continued From page 92 Furosemide 80 mg, which was then listed and entered onto the Medication Administration Observation form. LPN #9 was then observed emptying the package containing Furosemide 80 mg into a cup. LPN #9 then handed the empty package to this writer to confirm that the content of the package was Furosemide 80 mg. LPN #9 then proceeded to administer the Furosemide 80 mg to Resident #16 along with ten other ordered medications that were verified in the same manner as described for the Furosemide. A review of Resident #16's clinical record revealed, in part, the following physician order; dated 5/26/17, "Lasix (furosemide) tablet; 20 mg: amt (amount): 1 (one) tab (tablet): oral. Twice a Day. 09:00 AM, 05:00 PM." A review of Resident #16's MAR dated 5/1/17 - 5/31/17 revealed, in part, the following: "Order: Lasix (furosemide) tablet; 20 mg; Amount to Administer; 1 tab; oral. Frequency: Twice A Day. Start / End Date 5/26/2017 - 6/7/2017 (DC Date)." Under the columns for each date between 5/26/17 and 5/31/17 there were nursing initials documented, indicating administration of Furosemide 20 mg, at 9:00 a.m. and 5:00 p.m. each day. A review of Resident #16's MAR (medication administration record) dated 6/1/17 - 6/7/17 revealed, in part, the following; "Order: Lasix (furosemide) tablet; 20 mg (milligrams); Amount to Administer: 1 tab: oral. Frequency: Twice a Day. Diagnosis: [Dx (diagnosis): Unspecified diastolic (congestive) heart failure]. Start / End Date: 5/26/2017 - 6/7/2017 (DC (discontinue) Date)." LPN #9's initials were documented on 6/7/17 at 9:00 a.m., indicating that Furosemide 20	F 333	observed. It will be done weekly for four weeks, than monthly for 3 months to ensure compliance with medication administration professional standards. 4) Results of the audits presented to Quality Assurance Committee for review and recommendations.	

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mg was administered.

Further review of Resident #16's MAR revealed, initials of nursing under each date column, indicating that Resident #16 had received Furosemide 20 mg twice a day from 6/1/2017 through 6/7/2017.

A review of the monthly pharmacy medication review did not reveal any documentation regarding the Furosemide dosing.

On 6/7/17 at 1:00 p.m. LPN #9 was asked to open her medication cart and to pull out the medications ordered for Resident #16. Medications for all Residents were separated by time of administration and contained in sealed bags sorted by administration time. The only sealed bag for Resident #16 was for the medications to be administered at 5:00 p.m. on 6/7/17. The contents listed on the sealed bag included Furosemide 80 mg. Further inspection of the individual packets contained inside the sealed bag revealed one dose of Furosemide 80 mg.

LPN #9 was asked to access Resident #16's electronic MAR and to show this writer the physician order for Furosemide 80 mg. LPN #9 stated that the MAR listed Furosemide 20 mg to be administered twice a day. LPN #9 further stated that the order for Furosemide 20 mg had been discontinued and a new order for Furosemide 40 mg had been initiated to start on 6/7/17 at 5:00 p.m. LPN #9 was asked if she remembered administering Furosemide to Resident #16 that morning. LPN #9 stated that she did remember that she "threw away a dose because it wasn't right." When asked when she

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threw the incorrect dose away LPN #9 stated, "Before administering her (Resident #16's) meds (medications)." LPN #9 was asked if she remembered this writer's process prior to the administration of the medications. LPN #9 stated that she remembered that I wrote down each medication from the sealed package and then compared this to each medication contained within the sealed package. LPN #9 was asked again when she threw away the incorrect dose of Furosemide. LPN #9 stated, "I must have given it to her."

LPN #9 was asked to describe the process when administering medications. LPN #9 stated, "I should do the six rights." When asked to state the "six rights" LPN #9 responded, "Right medication, right patient, right dose and right time. I don't remember the other two." LPN #9 was asked how she verified the right dose. LPN #9 stated that she would compare the packaging with the electronic MAR prior to administering the medications. LPN #9 further stated, "I probably skipped over that dose this morning." When asked how the medications are delivered and checked into the facility, LPN #9 stated, "They are delivered between 12:00 a.m. and 1:00 a.m. and the night shift nurse checks them in. The pharmacy brings the next day's delivery and the nurse just checks them off from his list to make sure the delivery matches. The medications are not checked at that time against the MARs, the nurse delivering the medications checks that off prior to administering."

On 6/7/17 at approximately 1:10 p.m. an interview was conducted with OSM (other staff member) #9, the pharmacist. OSM #9 was asked how he received orders for medications to be filled from

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the facility. OSM #9 stated that it was through their automated system, as an order was entered it went directly to the pharmacy. OSM #9 was asked to look at Resident #16's medication orders and was asked to state the dosage for the current Furosemide order on file at the pharmacy. OSM #9 stated that the order for Furosemide had changed that day (6/7/17) from 80 mg twice a day to 40 mg twice a day. When asked how long the order for Furosemide 80 mg had been in place, OSM stated, "Furosemide was ordered originally on 12/19/16 for 80 mg and that is what has been sent since that date." When asked if there were any other orders for a different Furosemide dose in the pharmacy system, OSM #9 stated, "There are no other doses in our system." When asked what impact would occur if the resident was ordered Furosemide 20 mg twice a day and was actually receiving 80 mg a day. OSM #9 stated, "Weight loss, dehydration, loss of electrolytes and potassium. The resident may not have any issues but you would need to check closely."

On 6/7/17 at 1:30 p.m. an interview was conducted with OSM #10, the physician assistant. OSM #10 was asked if she worked with Resident #16 and she stated that she did. OSM #10 was asked if she had seen Resident #16 that day and OSM #10 stated that she had seen her at around 9:00 a.m. When asked if she (OSM #10) had made any changes to Resident #16's medications, OSM #10 stated that she had changed the dosing of Resident #16's Furosemide from 20 mg twice a day to Furosemide 40 mg twice a day. When asked if Resident #16 should have been receiving Furosemide 80 mg at any time between 5/26/17 and 6/7/17 OSM #10 stated no and that Resident

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#16 had been receiving Furosemide 80 mg for a short period of time in December 2016, but that was all. OSM #10 was asked what impact would receiving an 80 mg dose of Furosemide rather than 20 mg dose have on a patient. OSM #10 stated, "That is triple the dose and could lower the blood pressure and affect the kidneys. It could have a significant impact as it is a large increase." OSM #10 was asked if she had been made aware that the pharmacy had been only sending Furosemide 80 mg twice a day since 5/26/17. OSM #10 stated that she had not been made aware of that. OSM #10 was told at this time that a nurse was observed administering Furosemide 80 mg that morning and that the medication pack for 5:00 p.m. administration only contained Furosemide 80 mg. OSM #10 stated, "She (Resident #16) already has chronic kidney disease, I will definitely get the nurses to draw some lab work in the morning to make sure her potassium is not low and her electrolytes are okay."

On 6/7/17 at approximately 1:40 p.m. LPN #8, the director for compliance of quality improvement, was asked to obtain a pharmacy manifest for all medications delivered for Resident #16 beginning on 5/25/17 through 6/7/17.

On 6/7/17 at 3:50 p.m. LPN #8, the director for compliance of quality improvement, provided a pharmacy delivery manifest dated 6/6/17 that documented, a delivery of two Furosemide 80 mg tablets for Resident #16. There was no documentation to indicate that Furosemide 20 mg tablets had been delivered. When asked why the pharmacy was delivering Furosemide 80 mg when the physician order documented Furosemide 20 mg, LPN #8 stated that she did

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not know but was getting the pharmacy to "look into it." LPN #8 was asked again to provide the delivery manifests for Resident #16 from 5/26/17 through 6/7/17.

An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time and the request for the delivery manifest from 5/26/17 through 6/7/17, and any documentation that would evidence that the nursing staff were discarding the Furosemide 80 mg dose and were obtaining the Furosemide 20 mg to administer to Resident #16. A policy was also requested at this time regarding medication administration and medication requisition from the pharmacy.

On 6/8/17 at 8:45 a.m. an interview was conducted with LPN #1, the unit manager on Resident #16's unit. When asked what a nurse should do when getting ready to administer a medication LPN #1 stated, "There should be three checks, check the sealed bag against the MAR, check the resident's identity, and check the route for the medication to be delivered. The five rights should be completed, right med, right dose and right time. Then the nurse has to check each pill package within the bag against the MAR to ensure that the bag and contents match the MAR." When asked what happens when the medications delivered do not match the order on the MAR, LPN #1 stated that the order / medication delivered should be verified. LPN #1 was asked about Resident #16's Furosemide

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order. LPN #1 stated, "I don't know what happened there, it should have been questioned."

On 6/8/17 at 10:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to describe the process for a nurse ready to administer a medication to a resident. ASM #2 stated, "Identify the patient, conduct six rights of medication administration and check the medication against the MAR." When asked if the MAR and medication available does not match what should the nurse do, ASM #2 stated that the nurse should clarify the order and the medication.

On 6/8/17 at approximately 10:30 a.m. a pharmacy delivery manifest was provided that documented the delivery of Furosemide for Resident #16 since 12/20/2016. For the dates 5/25/17 through 6/8/17 the manifest documented that only Furosemide 80 mg was delivered for administration to Resident #16.

On 6/8/17 at 11:45 a.m. an interview was conducted with LPN #8. LPN #8 was asked what dose of Furosemide the nursing staff was administering to Resident #16 between 5/26/17 and 6/7/17. LPN #8 stated, "I am thinking that when nursing compared the doses provided with the MAR they just threw away the 80 mg dose." When asked if she knew for certain that the Furosemide 80 mg was being discarded every day, twice a day since 5/26/17, LPN #8 stated, "No I do not." When asked if the nursing staff were discarding the Furosemide 80 mg where the nurses were getting the correct dose from, LPN #8 stated, "I don't know, maybe the STAT (Immediate emergency medication) box." LPN #8 was asked to provide evidence that the

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nursing staff was retrieving Furosemide 20 mg from the STAT box twice a day since 5/26/17. LPN #8 was asked what nursing should do if they receive two different doses of medication. LPN #8 stated, "I don't know." LPN #8 was asked whether or not nursing should clarify the order with the physician and pharmacy. LPN #8 stated, "Yes." When asked what nursing did about the incorrect dose being delivered for Resident #16, LPN #8 stated, "I can't say."

On 6/8/17 at 12:10 p.m. an interview was conducted with RN (registered nurse) #3. RN #3 was asked to describe how the pharmacy delivered medications to the facility. RN #3 stated, "They send individually sealed bags with the medications due for the next date. Each bag contains a list of medications contained in the bag for a specific time." When asked what staff do if the bag has an incorrect dose listed. RN #3 stated, "We go by the MAR, regardless of what the bag shows because the pharmacy delivers in advance and the order may have changed. If there is a discrepancy we should research the discrepancy and call the pharmacy to reduce the risk of a med (medication) error. If the dose and the MAR do not match I should definitely call the pharmacy."

On 6/8/17 at approximately 1:00 p.m. LPN #8 provided documentation from the STAT box that evidence that on 6/4/17 at 5:00 p.m. a nurse retrieved Furosemide 20 mg to administer to Resident #16. LPN #8 stated that this was the only documentation since prior to 5/26/17 that a nurse had retrieved Furosemide 20 mg from the STAT box to administer to Resident #16.

A review of the facility policy titled, "Medication

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Administration - General Policies and Procedures" revealed, in part, the following documentation; "Policy: Medications are only administered as prescribed in accordance with good nursing principles and practices and by legally - authorized persons. Procedure: 1. C. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. 5. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition the nurse calls the provider pharmacy for clarification prior to the administration of the medication. The interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere, as appropriate, in the medical record. 20. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration."

"LASIX® is a diuretic which is an anthranilic acid derivative. PRECAUTIONS: particularly in elderly patients. This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection and it may be useful to monitor renal function.

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F 333	Continued From page 101 WARNING: LASIX® (furosemide) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose schedule must be adjusted to the individual patient's needs." (2) No further information was provided prior to the end of the survey process. (1) Furosemide is used alone or in combination with other medications to treat high blood pressure. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine. This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682858.html (2) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=EADFE464-720B-4DCD-A0D8-45DBA706BD33	F 333		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		7/19/17

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F 371	Continued From page 102 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store equipment in a sanitary manner. The findings include: On 6/6/17 at 11:29 a.m., an inspection of the kitchen was conducted. On one wall was a large steel storage rack with multiple wire-type shelves. On this rack was stored assorted sizes of steam table pans and lids, large baking sheets, and muffin tins for draining and drying after washing. The wire shelves were noted to be caked with a thick, dry, hardened light brown to cream colored substance that was sticky and tacky to the touch. On 6/6/17 at approximately 11:40 a.m., the shelves were pointed out to OSM #13 (Other Staff Member) the dietary manager. He began	F 371	F371 Food Sanitary Manner 1) The storage rack was replaced June 6, 2017. The Dietary Director was educated to store equipment in a sanitary manner. 2) All residents have the potential to be affected by this practice. A 100% audit of shelving units within the dietary area was accomplished with no similar issues found. 3) The dietary department staff were educated on: A. Maintaining storage area shelving that is clean and free of contamination. B. Policy for handling clean equipment and utensils, and that clean equipment and utensils will be stored in a clean location that protects them from contamination and dust. The Director of Dietary will complete a 100% audit of shelf storage units monthly to ensure safe, sanitary environment, and to ensure ongoing compliance with this	

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F 371	Continued From page 103 removing all the pans and bakeware from the shelves for cleaning. On 6/7/17 at 1:50 p.m., in an interview with OSM #13 he stated that the cart was grimy and that the pans and bakeware should not be stored on a grimy cart. A review of the facility policy "Handling Clean Equipment and Utensils" documented, "2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from contamination by splashes and dust. Stationary equipment will also be protected from contamination." On 6/8/17 at approximately 2:00 p.m., the Administrator was made aware of the findings. No further information was provided.	F 371	practice. 4) Results of the audit are presented to Quality Assurance Committee for review and recommendations.	
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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 resident interview, staff interview, clinical record review facility document review,	F 425	F425 Pharmaceutical Services, Accurate procedures, RPH	7/19/17

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F 425	Continued From page 104 complaint investigation, it was determined that facility staff failed to provide pharmaceutical services to meet the needs of three residents, (Resident #3, #5 and #22) of 28 residents in the survey sample. 1. The facility staff failed to ensure Resident #3's physician prescribed Latanprost eye drops were available for administration on 10/10/16 and 12/27/16. 2. The facility staff failed to ensure that Resident #16 received the correct dose of Furosemide (1), a diuretic, from the pharmacy. Clinical documentation revealed that the pharmacy sent Furosemide 80 mg (milligrams) two times daily between 5/26/17 and 6/6/17 when the physician order was for Furosemide 20 mg two times daily. 3. The facility staff failed to acquire Resident #22's donepezil for administration on 5/25/17. The findings include: 1. Resident #3 was admitted to the facility on 12/6/13 and readmitted on 4/29/14 with diagnoses that included but were not limited to spinal stenosis, Myasthenia gravis [1], heart failure, type two diabetes mellitus, chronic kidney disease, glaucoma, osteoarthritis and venous insufficiency. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/5/17. Resident #3 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from one staff member with transfers and	F 425	1) The physician was notified that Resident # 3 was not provided Latanprost eye drops for administration on 10/10/16 and 12/27/16. The physician was notified that Resident #22 did not receive Donepezil on 5/25/17. No new orders were received for either resident. The nurse staff # (3) was made aware that needs for medications are met by using the facility□s approved emergency medication supply or by special order from the contracted pharmacy. The physician was contacted regarding Resident #16 and the incorrect dose of Lasix and Lasix 40mg BID is given per physician order. The Licensed Nursing staff was provided education on medication administration consistent with professional standard of practice. Pharmacy staff was reeducated on the proper implementation of medication orders originating from the facility□s electronic health record (completed 6/26/17). 2) All residents who receive medications from Remedi pharmacy have the potential to be affected by the same practice. The pharmacy will complete a 100% medication reconciliation audit, comparing current medication orders in the medical record with the medication dispensed from the pharmacy, by July 7, 2017. Any discrepancies will be reported immediately to the Director of Nursing to be reconciled. a. All residents have the potential to be affected by the practice of medications not being available and / or documented when provided. The Matrix care medication administration compliance report will be	

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F 425	Continued From page 105 dressing; total dependence on staff with bathing; and independent with meals. Review of Resident #3's June 2017 POS (physician order sheet) revealed the following eye drop order: "Latanoprost [2] drops; 0.005%; amt (amount): 1 drop to each eye; ophthalmic [DX (diagnoses): Unspecified open -angle glaucoma, moderate stage. At Bedtime; 09:00 PM." This order was initiated on 4/29/2014. Review of Resident #3's August 2016 through June 2017 MARS (Medication Administration Record) revealed Resident #3 did not receive his Latanoprost 0.005% eye drops on the following dates: " 10/10/2016 " 12/27/2016 The following note was documented in the October 2016 MAR for 10/10/2016: "Scheduled date 10/10/2016. Scheduled time 9:00 PM. Charted Date-Time: 10/10/2016 09:53 PM. Reasons/Comments Not Administered: Drug/Item unavailable." The following note was documented in the December 2016 MAR for 12/27/2016: "Scheduled date: 12/27/16. Scheduled time 7:00 PM. Charted Date-Time: 12/27/2016 06:05 PM. Reasons/Comments: Not Administered: Drug/Item Unavailable Comment: faxed over to pharmacy." Review of the STAT (Immediately) box list revealed Latanoprost drops were not in the STAT box.	F 425	run each shift to ensure all medications were administered and available as ordered. 3) The Licensed Nursing staff were educated on: a. Medication administration and documentation consistent with professional standards of practice. b. Verifying dosage on Paxit bags and or medication packet compared to physician order on Medication administration record and medication packet to ensure medication is given per the physician order. c. Notify the physician if a regularly scheduled medication is withheld or refused for two consecutive does of a medication. d. Notification of physician and responsible party if a medication is not available or not administered as schedule. e. Using the facility□s approved emergency medication supply or by special order from the contracted pharmacy to meet medication needs. ¿ The pharmacy staff were educated on the proper implementation of medication orders originating from the facility□s electronic health record (completed 6/26/17). ¿ Remedi Pharmacy will complete a 100% monthly reconciliation audit again in August and September of 2017 comparing current medication orders in the medical record with medication dispensed from the pharmacy and any discrepancies will be immediately reported to the Director of Nursing to be reconciled. ¿ All new admissions and all new	

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F 425	Continued From page 106 Review of the nursing notes failed to reveal why Resident #3 did not receive his eye drops. There was no evidence in the clinical record that the physician was notified. On 6/7/17 at 9:00 a.m., an interview was conducted with Resident #3. When asked if he gets all medications at the scheduled time, Resident #3 stated that there was a few times in the past when his Latanoprost eye drops were not available from pharmacy. Resident #3 stated that this happened last year. Resident #3 stated that he made everyone aware that he did not receive his eye drops and the issue has since been resolved. When asked about his vision, Resident #3 stated, "I'm just going blind." On 6/7/17 at 1:40 p.m., an interview was conducted with ASM (administrative staff member) #6, Resident #3's physician assistant. When asked what she would expect nurses to do if a resident ran out of medication, ASM #6 stated that she would expect nursing to notify her or the physician. ASM #6 stated that her orders or directions in response to being notified would depend on the type of medication missed. ASM #6 stated that for Resident #3, she would expect nursing to also notify his eye physician. When asked if missing one dose of Latanoprost eye drops in one month would have any impact on the Resident, ASM #6 stated, "With my basic knowledge of Latanoprost drops, missing a dose could increase the pressure in the eyes which could have detrimental effects." ASM #6 could not recall the above events. ASM #6 could not recall if she was made aware that Resident #3's eye drops were missing on 10/10/16 and 12/27/16.	F 425	physician orders will be reviewed daily in clinical meeting to ensure continued compliance. ¿ Administration compliance report will be run each shift to ensure all medications were administered as ordered. ¿ Administration compliance reports will be reviewed in morning clinical meeting each day to ensure compliance of medication administration and availability. ¿ The DON or designee will audit MAR□s for 20 residents for omissions, physician notification and med availability weekly for four weeks and monthly for 2 months. 4) The director of nursing or designee will report all audit results related to Pharmacy Services to Quality Assurance committee for trending and analysis monthly.	

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On 6/7/17 at 5:23 p.m., an interview was conducted with LPN (licensed practical nurse) #16, the nurse who documented that the eye drops were not available on 10/10/16. LPN #16 was asked about the process followed by staff if a medication scheduled for administration is not available. LPN #16 stated that she would pull the medication from the drawer for the next day and then call pharmacy to have them send over more medication STAT (Immediately). LPN #16 was asked what staff do if a scheduled medication is not obtained from the pharmacy for administration at the time. LPN #16 stated, "Honestly I haven't had that happen. I would call the MD (medical doctor)." When asked when nurses should refill medications, LPN #16 stated, "Some medications have a line that says refill point that means it should be refilled if the medications get that low." LPN #16 stated that she also refills medications on Fridays if medications look like they might run out over the weekend. LPN #16 stated, "There are not many medication runs on the weekends." LPN #16 was asked when nursing should re-fill eye drops. LPN #16 stated, "When there is about a quarter left in the bottle." When asked if she could recall if Resident #3 received his eye drops on 10/10/16, LPN #16 stated that she had called pharmacy when she saw the eye drops were gone. LPN #16 stated that the resident did not receive his drops that night but she passed on to the night shift nurse that his drops were coming. When asked if she notified the physician that Resident #3 did not receive his eye drops that shift, LPN #16 stated, "I don't believe I did. It was my first week here."

On 6/8/17 at 9:46 a.m., an interview was conducted with LPN (licensed practical nurse) #3, the unit manager. When asked about the

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process followed by staff if a medication is not available to be administered, LPN #3 stated he would expect nurses to call pharmacy and have them send the medication. LPN #3 also stated he would expect nurses to call the physician so the physician can give a verbal order to hold the medication until it arrived to the facility. LPN #3 stated he expected nurses to document this information in the nursing notes. LPN #3 stated medications should be refilled two days before they run out.

On 6/8/17 at 10:17 a.m., an interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 was asked about the process followed by staff if a resident's medication ran out when it was supposed to be administered. ASM #2 stated that she would expect her nurses to call the pharmacy if the STAT box (a box containing various medications) did not carry the medication, and to have the pharmacy send the medication STAT. ASM #2 stated she would expect her nurses to notify the MD (medical doctor) if the resident could not get their scheduled dose of medication.

On 6/8/17 at 11:08 a.m., an interview was conducted with RN (registered nurse) #5, the nurse supervisor, regarding the process followed by staff when scheduled medications have run out and are not available for administration. RN #5 stated that nursing should be checking the STAT box first to see if the medication is in there. RN #5 stated that if the medication is not available in the STAT box, nursing should call pharmacy and have pharmacy send over medications STAT. RN #5 stated that nursing should also be notifying the physician so the physician can give a verbal order to hold the

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medication until it arrives from pharmacy.

On 6/8/17 at 9:55 a.m., an interview was conducted with OSM (Other Staff Member) #12, the pharmacist. When asked the impact of a resident missing one dose of Lantanoprost eye drops one day out of one month, OSM #12 stated, "Looking at this study it says that Lantanoprost drops hold its effectiveness for at least 24 hours. There should be no effect with missing one dose."

The nurse who administered the medication on 12/27/16 could not be reached for an interview.

On 6/8/17 at 12:05 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Ordering Procedures (New Orders and Reorder) document in part, the following: "...2. Reorders (refills) Reorders are processed by peeling the small, yellow label from the larger pharmacy label and placing it on the Reorder request form. Fax the form to pharmacy...contact the pharmacy immediately if an expected medication does not arrive...STAT Orders: During regular pharmacy hours, please call pharmacy to give the order to a pharmacist. STAT medications are delivered and administered according to the physician orders. If available, the initial dose is obtained from the emergency box supply...Facilities are encouraged to carefully check medication quantities on Wednesday's to ensure adequate supply is available for the weekend."

No further information was presented prior to exit.

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F 425	Continued From page 110 COMPLAINT DEFICIENCY [1] "Myasthenia gravis is a disease that causes weakness in your voluntary muscles. These are the muscles that you control. For example, you may have weakness in the muscles for eye movement, facial expressions, and swallowing. You can also have weakness in other muscles. This weakness gets worse with activity, and better with rest." This information was obtained from The National Institutes of Health. https://medlineplus.gov/myastheniagravis.html. [2] "Latanoprost is used to treat certain kinds of glaucoma. It is also used to treat a condition called hypertension of the eye. Latanoprost appears to work by increasing the outflow of fluid from the eye. It decreases pressure in the eye." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010869/?report=details. 2. The facility staff failed to ensure that Resident #16 received the correct dose of Furosemide (1), a diuretic, from the pharmacy. Clinical documentation revealed that the pharmacy sent Furosemide 80 mg (milligrams) two times daily between 5/26/17 and 6/6/17 when the physician order was for Furosemide 20 mg two times daily. Resident #16 was admitted to the facility on 12/10/16 with diagnoses that included, but were not limited to; chronic obstructive pulmonary disease, heart failure, diabetes, peripheral vascular disease and high blood pressure. Resident #16's most recent MDS (minimum data	F 425		

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set) is a quarterly assessment with an ARD (assessment reference date) of 3/15/17. Resident #16 was coded as scoring eight out of a possible 15 in Section C, Cognitive Patterns, BIMS (brief interview for mental status), indicating that Resident #16 is moderately cognitively impaired with daily decision making. Section N, Medications, codes Resident #16 as receiving a diuretic each day.

During medication administration observation on 6/7/17 at 8:30 a.m. LPN (licensed practical nurse) #9 was observed administering Furosemide, a diuretic, 80 mg (milligrams). The medication was individually wrapped with a label and placed in a sealed bag, along with other medications to be administered on 6/7/17 at 9:00 a.m., and a list of the medications enclosed printed on the sealed bag. LPN #9 was observed comparing the list on the sealed bag with the electronic MAR. LPN #9 then opened the bag and removed the individually wrapped medications to be administered. LPN #9 then proceeded to compare the contents of the package with the list on the front of the package and the MAR. LPN #9 handed the package to this writer, the package documented Furosemide 80 mg, which was then listed and entered onto the Medication Administration Observation form. LPN #9 was then observed emptying the package containing Furosemide 80 mg into a cup. LPN #9 then handed the empty package to this writer to confirm that the content of the package was Furosemide 80 mg. LPN #9 then proceeded to administer the Furosemide 80 mg to Resident #16 along with ten other ordered medications that were verified in the same manner as described for the Furosemide.

A review of Resident #16's clinical record

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revealed, in part, the following physician order; dated 5/26/17, "Lasix (furosemide) tablet; 20 mg: amt (amount): 1 (one) tab (tablet): oral. Twice a Day. 09:00 AM, 05:00 PM."

A review of Resident #16's MAR dated 5/1/17 - 5/31/17 revealed, in part, the following: "Order: Lasix (furosemide) tablet; 20 mg; Amount to Administer; 1 tab; oral. Frequency: Twice A Day. Start / End Date 5/26/2017 - 6/7/2017 (DC Date)." Under the columns for each date between 5/26/17 and 5/31/17 there were nursing initials documented, indicating administration of Furosemide 20 mg, at 9:00 a.m. and 5:00 p.m. each day.

A review of Resident #16's MAR (medication administration record) dated 6/1/17 - 6/7/17 revealed, in part, the following; "Order: Lasix (furosemide) tablet; 20 mg (milligrams); Amount to Administer: 1 tab: oral. Frequency: Twice a Day. Diagnosis: [Dx (diagnosis): Unspecified diastolic (congestive) heart failure]. Start / End Date: 5/26/2017 - 6/7/2017 (DC (discontinue) Date)." LPN #9's initials were documented on 6/7/17 at 9:00 a.m., indicating that Furosemide 20 mg was administered.

Further review of Resident #16's MAR revealed, in part, nursing initials under each date column (indicating that Resident #16 had received Furosemide 20 mg twice a day) from 6/1/2017 through 6/7/2017.

A review of the monthly pharmacy medication review did not reveal any documentation regarding the Furosemide dosing.

On 6/7/17 at 1:00 p.m. LPN #9 was asked to

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open her medication cart and to pull out the medications ordered for Resident #16. Medications for all Residents were separated by time of administration and contained in sealed bags sorted by administration time. The only sealed bag for Resident #16 was for the medications to be administered at 5:00 p.m. on 6/7/17. The contents listed on the sealed bag included Furosemide 80 mg. Further inspection of the individual packets contained inside the sealed bag revealed one dose of Furosemide 80 mg.

LPN #9 was asked to access Resident #16's electronic MAR and to show this writer the physician order for Furosemide 80 mg. LPN #9 stated that the MAR listed Furosemide 20 mg to be administered twice a day. LPN #9 further stated that the order for Furosemide 20 mg had been discontinued and a new order for Furosemide 40 mg had been initiated to start on 6/7/17 at 5:00 p.m. LPN #9 was asked if she remembered administering Furosemide to Resident #16 that morning. LPN #9 stated that she did remember that she "threw away a dose because it wasn't right." When asked when she threw the incorrect dose away LPN #9 stated, "Before administering her (Resident #16's) meds (medications)." LPN #9 was asked if she remembered this writer's process prior to the administration of the medications. LPN #9 stated that she remembered that I wrote down each medication from the sealed package and then compared this to each medication contained within the sealed package. LPN #9 was asked again when she threw away the incorrect dose of Furosemide. LPN #9 stated, "I must have given it to her."

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LPN #9 was asked to describe the process when administering medications. LPN #9 stated, "I should do the six rights." When asked to state the "six rights" LPN #9 responded, "Right medication, right patient, right dose and right time. I don't remember the other two." LPN #9 was asked how she verified the right dose. LPN #9 stated that she would compare the packaging with the electronic MAR prior to administering the medications. LPN #9 further stated, "I probably skipped over that dose this morning." When asked how the medications are delivered and checked into the facility, LPN #9 stated, "They are delivered between 12:00 a.m. and 1:00 a.m. and the night shift nurse checks them in. The pharmacy brings the next day's delivery and the nurse just checks them off from his list to make sure the delivery matches. The medications are not checked at that time against the MARs, the nurse delivering the medications checks that off prior to administering."

On 6/7/17 at approximately 1:10 p.m. an interview was conducted with OSM (other staff member) #9, the pharmacist. OSM #9 was asked how he received orders for medications to be filled from the facility. OSM #9 stated that it was through their automated system, as an order was entered it went directly to the pharmacy. OSM #9 was asked to look at Resident #16's medication orders and was asked to state the dosage for the current Furosemide order on file at the pharmacy. OSM #9 stated that the order for Furosemide had changed that day (6/7/17) from 80 mg twice a day to 40 mg twice a day. When asked how long the order for Furosemide 80 mg had been in place, OSM stated, "Furosemide was ordered originally on 12/19/16 for 80 mg and that is what has been sent since that date." When asked if there were

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any other orders for a different Furosemide dose in the pharmacy system, OSM #9 stated, "There are no other doses in our system."

On 6/7/17 at approximately 1:40 p.m. LPN #8, the director for compliance of quality improvement, was asked to obtain a pharmacy manifest for all medications delivered for Resident #16 beginning on 5/25/17 through 6/7/17.

On 6/7/17 at 3:50 p.m. LPN #8, the director for compliance of quality improvement, provided a pharmacy delivery manifest dated 6/6/17 that documented, a delivery of two Furosemide 80 mg tablets for Resident #16. There was no documentation to indicate that Furosemide 20 mg tablets had been delivered. When asked why the pharmacy was delivering Furosemide 80 mg when the physician order documented Furosemide 20 mg, LPN #8 stated that she did not know but was getting the pharmacy to "look into it." LPN #8 was asked again to provide the delivery manifests for Resident #16 from 5/26/17 through 6/7/17.

An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time and the request for the delivery manifest from 5/26/17 through 6/7/17, and any documentation that would evidence that the nursing staff were discarding the Furosemide 80 mg dose and were obtaining the Furosemide 20 mg to administer to Resident #16. A policy was also requested at this time regarding

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medication administration and medication requisition from the pharmacy.

On 6/8/17 at 8:45 a.m. an interview was conducted with LPN #1, the unit manager on Resident #16's unit. When asked what a nurse should do when getting ready to administer a medication LPN #1 stated, "There should be three checks, check the sealed bag against the MAR, check the resident's identity, and check the route for the medication to be delivered. The five rights should be completed, right med, right dose and right time. Then the nurse has to check each pill package within the bag against the MAR to ensure that the bag and contents match the MAR." When asked what happens when the medications delivered do not match the order on the MAR, LPN #1 stated that the order / medication delivered should be verified. LPN #1 was asked about Resident #16's Furosemide order. LPN #1 stated, "I don't know what happened there, it should have been questioned."

On 6/8/17 at 10:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked to describe the process for a nurse ready to administer a medication to a resident. ASM #2 stated, "Identify the patient, conduct six rights of medication administration and check the medication against the MAR." When asked if the MAR and medication available does not match what should the nurse do, ASM #2 stated that the nurse should clarify the order and the medication.

On 6/8/17 at approximately 10:30 a.m. a pharmacy delivery manifest was provided that documented the delivery of Furosemide for Resident #16 since 12/20/2016. For the dates

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5/25/17 through 6/8/17 the manifest documented that only Furosemide 80 mg was delivered for administration to Resident #16.

On 6/8/17 at 11:45 a.m. an interview was conducted with LPN #8. LPN #8 was asked what dose of Furosemide the nursing staff was administering to Resident #16 between 5/26/17 and 6/7/17. LPN #8 stated, "I am thinking that when nursing compared the doses provided with the MAR they just threw away the 80 mg dose." When asked if she knew for certain that the Furosemide 80 mg was being discarded every day, twice a day since 5/26/17, LPN #8 stated, "No I do not." When asked if the nursing staff were discarding the Furosemide 80 mg where the nurses were getting the correct dose from, LPN #8 stated, "I don't know, maybe the STAT (Immediately - emergency medication) box." LPN #8 was asked to provide evidence that the nursing staff was retrieving Furosemide 20 mg from the STAT box twice a day since 5/26/17. LPN #8 was asked what nursing should do if they receive two different doses of medication. LPN #8 stated, "I don't know." LPN #8 was asked whether or not nursing should clarify the order with the physician and pharmacy. LPN #8 stated, "Yes." When asked what nursing did about the incorrect dose being delivered for Resident #16, LPN #8 stated, "I can't say."

On 6/8/17 at 12:10 p.m. an interview was conducted with RN (registered nurse) #3. RN #3 was asked to describe how the pharmacy delivered medications to the facility. RN #3 stated, "They send individually sealed bags with the medications due for the next date. Each bag contains a list of medications contained in the bag for a specific time." When asked what staff do if

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the bag has an incorrect dose listed. RN #3 stated, "We go by the MAR, regardless of what the bag shows because the pharmacy delivers in advance and the order may have changed. If there is a discrepancy we should research the discrepancy and call the pharmacy to reduce the risk of a med (medication) error. If the dose and the MAR do not match I should definitely call the pharmacy."

On 6/8/17 at approximately 1:00 p.m. LPN #8 provided documentation from the STAT box that evidence that on 6/4/17 at 5:00 p.m. a nurse retrieved Furosemide 20 mg to administer to Resident #16. LPN #8 stated that this was the only documentation since prior to 5/26/17 that a nurse had retrieved Furosemide 20 mg from the STAT box to administer to Resident #16.

A review of the facility policy titled, "Medication Administration - General Policies and Procedures" revealed, in part, the following documentation; "Policy: Medications are only administered as prescribed in accordance with good nursing principles and practices and by legally - authorized persons. Procedure: 1. C. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. 5. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or

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condition the nurse calls the provider pharmacy for clarification prior to the administration of the medication. The interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere, as appropriate, in the medical record. 20. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration."

No further information was provided prior to the end of the survey process.

(1) Furosemide is used alone or in combination with other medications to treat high blood pressure. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine. This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682858.html

3. The facility staff failed to acquire Resident #22's donepezil (1) for administration on 5/25/17.

Resident #22 was admitted to the facility on 5/25/17. Resident #22's diagnoses included but were not limited to: heart disease, high blood pressure and generalized anxiety disorder. Resident #22's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 6/1/17, coded the resident's cognition as moderately impaired.

Review of Resident #22's clinical record revealed

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a nurse's note dated 5/25/17 that documented the resident was admitted to the facility on that day at 4:00 p.m.

Resident #22's admission physician's orders dated 5/25/17 documented an order for donepezil 5 mg (milligrams) once a day at 9:00 p.m.

Resident #22's May 2017 MAR (medication administration record) documented donepezil 5 mg was not administered on 5/25/17 at 9:00 p.m. The MAR notes documented, "Not Administered: On Hold. Comment: give as soon as in from pharmacy." The MAR and nurses' notes for 5/25/17 failed to document the medication was given that night.

Review of the facility STAT box list revealed donepezil was not in the STAT (Immediately) box (a box containing various medications).

Resident #22's comprehensive care plan revised on 5/31/17 failed to document information regarding donepezil administration.

The nurse responsible for administering 9:00 p.m. medications to Resident #22 on 5/25/17 was not available for interview.

On 6/8/17 at 9:24 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if the facility had a process to ensure medications were available for a newly admitted resident. LPN #3 stated when a new resident is admitted he faxes the resident's face sheet to the pharmacy, lets the physician approve the medications and enters the medications into the computer system that goes to the pharmacy. LPN #3 stated if a medication is needed then he

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F 425	Continued From page 121 obtains the medication from the STAT box or he calls the pharmacy to obtain the medication STAT (immediately). LPN #3 was asked if 9:00 p.m. medications should be available for a resident who is admitted at 4:00 p.m. on the same day. LPN #3 stated, "Yes. You should figure out a way to get it." On 6/8/17 at 10:00 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality assurance clinical nurse consultant) were made aware of the above concern. The facility policy titled, "Emergency Supply Kits" documented, "POLICY: Emergency pharmaceutical service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the contracted pharmacy..." No further information was presented prior to exit. (1) Donepezil is used to treat dementia (mental changes and memory loss). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010014/?report=details	F 425		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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:	F 441		7/19/17

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(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(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

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F 441	Continued From page 123 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, facility document review and clinical record review, it was determined that the facility staff failed to provide wound care in a manner to prevent infection for two of 28 residents in the survey sample, Resident #'s 5 and 1. 1. During wound care observation for Resident #5, LPN (licensed practical nurse) #11 was observed not using a clean field for supplies, using equipment that was not cleaned prior to use and not washing her hands prior to, during and after the wound care was completed. 2. The facility staff failed to clean scissors prior to providing wound care for Resident #1. The findings include:	F 441	F 441 Infection Control 1) Wound care was immediately re-done on resident #5 and #1. The licensed nursing staff involved was educated immediately on proper wound care procedures, hand hygiene and cleaning scissors with alcohol before and after use. 2) All residents who had wound care provided by staff # (6) and (11) have the potential to be affected by the same practice. The DON or designee will conduct a 100% observational audit of all residents who receive wound care from staff # (6) and (11), and any similar issues were addressed immediately. 3) The licensed nursing staff were provided education on: a. Wound care consistent with professional standards of practice	

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F 441	Continued From page 124 1. During wound care observation for Resident #5, LPN (licensed practical nurse) #11 was observed not using a clean field for supplies, using equipment that was not cleaned prior to use and not washing her hands prior to, during and after the wound care was completed. Resident #5 was admitted to the facility on 1/28/16 with diagnoses that included, but were not limited to, anoxic brain damage (caused by a period of time without oxygen), dysphagia (difficulty with swallowing), aphasia (difficulty with speaking), disease of the heart, diabetes, high level of lipids in the blood stream and osteomyelitis (an infection of the bone). Resident #5's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 5/1/17. Resident #5 was coded as being unable to complete the interview for Section C, BIMS (brief interview for mental status), a staff assessment was completed and coded Resident #5 as a 3 (three), indicating that Resident #5 is severely cognitively impaired with daily decision making. A review of Resident #5's clinical record revealed, in part, a nurse's note dated 5/3/17 documenting two pressure ulcers on Resident #5's left foot second toe. A treatment was put into place and Resident #5 was seen by the wound nurse on 5/5/17 and then by a wound care physician on 5/9/17. A review of Resident #5's clinical record revealed, a wound care specialist evaluation dated 6/6/17, that documented, in part, the following: "Unstageable (1) (Due to Necrosis) of the left,	F 441	b. Hand Hygiene during wound care c. Cleaning scissors with alcohol before and after use. d. The DON or designee will complete a 25% weekly audit of current residents receiving wound care for completion of the wound care treatment consistent with professional standards of practice to promote healing, prevent infection, prevent new ulcers from developing, and to ensure ongoing compliance with practice. If deficient practice is observed during observational audit, then that nurse will be educated and another observation of the same nurse will be repeated to ensure compliance. 4) Results of the audit presented to Quality Assurance Committee for review and recommendations.	

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dorsal (back), posterior (behind), second toe. Stage 3 (three) Pressure Wound of the left, dorsal, anterior (front), second toe." Treatments were in place.

A review of Resident #5's comprehensive care plan dated 5/31/17 revealed, in part, the following documentation; "Problem: Problem start date: 5/5/17. Resident Currently has Pressure ulcer to L (left) 2nd toe and is at risk for further skin breakdown. Edited: 5/31/2017. Goal: Short Term Goal Target Date: 8/16/2017. Pressure ulcer will show evidence of healing and will be free of signs and symptoms of infection by next review. Edited: 5/16/2017." There were no directives regarding daily wound care.

On 6/7/17 at 2:40 p.m. a wound care observation was conducted. LPN (licensed practical nurse) #11 was observed providing wound care to Resident #5's left second toe pressure ulcers. Resident #5 remained seated in a geri-chair in a reclined position beside his bed. LPN #11 drew the privacy curtain around Resident #5. LPN #11 explained that Resident #5's foot was contracted and it was often difficult to extend his leg outward to be able to get to the toes on the left foot. LPN #11 extended Resident #5's left heel to rest on the foot rest. LPN #11 gathered her supplies; 4 x 4 gauze, a kerlix bandage, a foam bandage, tape measure and normal saline bullets. LPN #11 laid all the supplies on top of Resident #5's bed, the gauze was in direct contact with the blanket over the bed. LPN #11 positioned Resident #5 and then picked up all the supplies and placed them on a bedside table. The table had not been wiped down and a protective pad was not placed over the table. LPN #11 was not observed washing her hands, but did put on gloves. LPN

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#11 then removed scissors from her pocket and proceeded to remove Resident #5's sock from his left foot; the sock was laid on the floor. LPN #11 then cut away the old bandage dressing with the scissors removed from her pocket. LPN # 11 then returned the scissors to her pocket and threw the old bandage into the trash can beside Resident #5's bed. Resident #5's toes were observed contracted under the foot and the wounds were dry, without exudate. LPN #11 took the 4 x 4 gauze from the table held the gauze directly beneath the wound areas on the toe and retrieved a normal saline bullet, and squirted normal saline directly into the wound, catching the excess normal saline in the gauze pad. At this time this writer asked LPN #11 to obtain measurements of the wound. LPN #11 reached onto the table to retrieve her tape measure from the table and placed it directly onto the wounds to obtain measurements. LPN #11 stated that there was only one wound as both wounds had joined. A measurement was obtained as 2.5 cm (centimeters) x 1.7 cm x (unable to obtain depth). Once the measurement was completed, LPN #11 threw away the tape measure and gauze pads into the bedside trash can and then applied hydrogel (2), directly to the wound. LPN #11 retrieved the foam dressing from the table and applied the foam dressing to the wound; she then retrieved the kerlix bandage from the table and wrapped Resident #5's foot. Once the bandage had been applied, LPN #11 retrieved the sock from the floor and placed it back on Resident #5's foot. At no time during this wound care process was LPN #11 observed washing her hands and/or applying hand sanitizer. LPN #11 was also not observed changing her gloves.

LPN #11 exited the room and was interviewed at

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the treatment cart about the wound treatment process above. LPN #11 was asked whether or not she provided a clean area for her supplies. LPN #11 stated, "No I didn't, and I don't know why I didn't do that, I just didn't." When asked about the use of the bedside table, LPN #11 stated that she did not clean the table before starting and should have. LPN #11 was asked why it was important to provide a clean area for the supplies, LPN #11 stated, "To prevent infection." LPN #11 was asked about cleaning her scissors. LPN #11 stated that she had cleaned them at the beginning of the shift. LPN #11 was asked where she kept her scissors, LPN #11 stated, "In my pocket." LPN #11 was asked if her pocket was clean, LPN #11 stated, "No, not really I keep my keys and marker in there too." LPN #11 was asked about when she measured the wound, LPN #11 stated, "I know, I should have re-cleaned the wound after placing the tape measure against the wound." LPN #11 was asked why she should have done that, LPN #11 stated, "I contaminated the wound." LPN #11 was asked about hand washing, LPN #11 stated that she should have washed her hands between removing the soiled dressing and applying the new dressing. When asked if she had done that LPN #11 stated that she had not.

An end of day meeting was conducted on 6/7/17 at 5:35 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate quality assurance clinical nurse consultant and ASM #4, the assistant director of nursing. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concern at this time. A policy was request regarding wound care and dressing changes.

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A review of the facility policy "Dressing Change (Clean)" revealed, in part, the following documentation; "Purpose: To protect a wound; to prevent infection and / or spread of infection; and to promote healing. Procedure: 3. Wash hands. 5. Place plastic bag near the foot of the bed to receive the soiled dressing. 6. Create the clean field with paper towels or disposable drape. 8. Put on the first pair of gloves. 9. Remove soiled dressing and discard in a plastic bag. 10. Dispose of gloves in the plastic bag. 11. Wash hands and put on the clean pair of gloves. 16. Remove gloves and discard with all unused supplies in plastic bag. 17. Wash hands."

A review of the facility policy "Infection Control - Hand Hygiene" revealed, in part, the following documentation; "POLICY: Facility staff follow hand hygiene procedures to improve hand hygiene practices and reduce transmission of pathogenic microorganisms to residents and personnel in the facility. Hand Hygiene is required: d. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings even if hands are not visibly soiled."

On 6/8/17 at 10:00 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked about the wound care and the process for conducting wound care. ASM #2 stated, "Review the order, gather supplies and use appropriate infection control practices." ASM #2 was asked to elaborate on the infection control practices as it pertained to wound care. ASM #2 stated, "Hand washing, maintain a clean environment when conducting wound care." ASM

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#2 further stated that the facility was going to re-educate all the nursing staff.

No further information was provided prior to the end of the survey process.

(1) Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.
(2) http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.

A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blancheable erythema of intact skin
Intact skin with a localized area of non-blancheable erythema, which may appear differently in darkly pigmented skin. Presence of blancheable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

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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
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.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or

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eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

This information was obtained from the following website:
http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

(2) Hydrogel dressings consist of 90 percent water in a gel base, according to the medical journal Apple Bites, and serves to help monitor fluid exchange from within the wound surface. By keeping the wound moist, the hydrogel dressing assists in protecting your body from wound infection and promotes efficient healing. This information was obtained from the following website;
https://www.advancedtissue.com/use-hydrogel-wound-care/

2. The facility staff failed to clean scissors prior to providing wound care for Resident #1's pressure injury.

Resident #1 was admitted to the facility on 10/14/10. Resident #1's diagnoses included but

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were not limited to: chronic kidney disease, major depressive disorder and anxiety disorder. Resident #1's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/15/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #1's clinical record revealed the resident presented with an unstageable pressure injury (1) on the left upper calf. Resident #1's comprehensive care plan revised on 5/31/17 documented, "new opened area on back of left lower extremity...treatment as ordered..."

On 6/7/17 at 11:05 a.m. this surveyor observed LPN (licensed practical nurse) #6 provide wound care for Resident #1. LPN #6 pulled scissors and a Sharpie marker out of her pocket. LPN #6 failed to clean the scissors before using them to cut a dressing that was placed on Resident #1's wound. Immediately after wound care an interview was conducted with LPN #6. LPN #6 was asked what other objects were in her pocket. LPN #6 stated she had a set of keys in her pocket. LPN #6 was made aware of this surveyor's observation. LPN #6 stated she cleaned her scissors with bleach after she provided wound care to the previous resident. LPN #6 was made aware the scissors were in her pocket with a marker and a set of keys. LPN #6 confirmed she should have cleaned the scissors after she removed them from her pocket.

On 6/7/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the corporate quality assurance clinical nurse consultant) and

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ASM #4 (the assistant director of nursing) were made aware of the above findings.

The facility policy titled, "DRESSING CHANGE (CLEAN)" documented, "PURPOSE: To protect a wound; to prevent irritation; to prevent infection and/or spread of infection; and to promote healing. JUSTIFICATION: Many times when a dressing is to be changed or applied, sterile dressings are not needed. The use of clean technique and clean dressings will provide the adequate treatment coverage to enhance healing while preventing and treating infections..."

In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your patients sick.
In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and gram-negative bacilli. The solution is quite simple. If health care workers swab the scissors with alcohol after each use, they will virtually eliminate the risk of transmission of microorganisms. In the study, contaminated scissors were effectively disinfected after swabbing the scissors with alcohol.
Reference:
Embil JM, Dyck B, McLeod J, et al. Scissors as a potential source of nosocomial infection? Presented at the 4th Decennial International Conference on Nosocomial and Healthcare-Associated Infections. Atlanta; March 8, 2000

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F 441	Continued From page 134 No further information was provided prior to exit. (1) "Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 441		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		7/19/17

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F 514	Continued From page 135 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for four of 28 residents in the survey sample; Residents #12, #28, #18, and #1. 1. a. The facility staff failed to accurately record Resident #12's pulse. b. The facility staff failed to ensure monthly pharmacy reviews were available on Resident	F 514	F 514 Resident records/complete/accurate/accessible 1) Resident #12 □ Pulse was entered correctly as 61 on 6/7/17. Resident # 12 □ Pharmacy monthly reviews were completed per the Consultant Pharmacist report for April and May. Resident #28 □ monthly weights were entered for April and May. Resident #18 □ Per licensed nurse interview, the medications were administered. Resident #1 □ Activity Care plan was initiated on 6/7/17. The licensed	

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F 514	Continued From page 136 #12's clinical record. 2. The facility staff failed to record Resident #28's weights in the clinical record. 3. The facility staff failed to document the administration of Resident # 18's medications on the eMAR (electronic medication administration record). 4. The facility staff failed to ensure Resident #1's clinical record contained an activities care plan. The findings include: 1. a. The facility staff failed to accurately record Resident #12's pulse. Resident #12 was admitted to the facility on 9/23/15 with the diagnoses of but not limited to pain, heart disease, congestive heart failure, myopathy, atrial fibrillation, spinal stenosis, diabetes, benign prostatic hypertrophy, chronic obstructive pulmonary disease, a lung mass and a pacemaker. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 3/18/17. The resident was coded as being mildly cognitively impaired in ability to make daily life decisions, scoring an 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, transfers, and dressing; supervision for eating;	F 514	nursing staff involved was educated on the medication administration policy and on entering vital signs timely and accurately. The admissions nurse and activity director were educated on initiating an Activities Care Plan on admission. The consultant pharmacist was educated to document in the medical record every time a drug regimen review is completed (completed 6/27/17). 2) All residents have the potential to be affected by the same practice. The Director of Nursing or designee conducted a 100% audit of all residents current pulse and weight vital signs documented in the EMAR, any similar issues were addressed immediately on the unit where the error occurred in the past 30 days of current residents. a. DON or designee will conduct a 100% audit of all residents activity care plans, any issues were addressed immediately. b. Remedi pharmacy□s lead consultant will complete 100% audit of active medical records (on or before 7/7/2017) to ensure documentation of completion of drug regimen review. 3) The licensed nursing staff were educated on: a. Medication Administration Policy b. The CNA and licensed nursing staff were educated on accurate vital sign data entry into the medical record. c. The consultant pharmacist was educated to document in the medical record every time a drug regimen review is performed (completed 6/27/17). d. Once every month for three months, beginning on August 7, 2017, the lead	

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F 514	Continued From page 137 and as incontinent of bowel and bladder. A review of the clinical record revealed that on 6/3/17, a pulse rate of 20 (The usual resting pulse for an adult is 60 to 100 beats per minute [1]) was documented in the electronic clinical record. There was no other indication that there were any concerns with Resident #12's vital signs that day. On 6/8/17 at 11:48 a.m., in an interview with CNA #14 (Certified Nursing Assistant) she stated that vital signs should be recorded accurately because it can adversely alter the care and medications a resident is given. On 6/8/17 at 12:02 p.m., during an interview with LPN #14 (Licensed Practical Nurse), she stated that if she were made aware that a resident had an abnormal vital sign, that she would reassess for accuracy, and if the reading was accurate she would call the doctor. LPN #14 stated that if it was not accurate, she would question the CNA that obtained and documented the vital sign and educate the CNA on accurate documentation and normal ranges of vital signs. LPN #14 stated that inaccurate vital signs can alter the care a resident receives and cause them to get a medication they should not receive or to not get a medication they need. A policy for accurate documentation was requested on 6/7/17 at approximately 5:45 p.m., at the end of day meeting, but was not provided. On 6/8/17 at approximately 2:00 p.m., the Administrator, ASM (administrative staff member) #1, was made aware of the findings. No further information was provided.	F 514	consultant pharmacist from Remedi will review approximately one third of the active medical records to assure that the consultant pharmacist has documented the completion of the drug regimen review. Discrepancies will be immediately discussed with the consultant pharmacist. e. The DON or designee will audit weekly to ensure that pulse and weight vitals are entered accurately and timely. f. Activity Department or designee will audit weekly that there is an Activity Care Plan initiated for each new resident. 4) Results of all audits to ensure accurate medical records will be presented to the Quality Assurance committee for review and recommendations.	

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b. The facility staff failed to ensure monthly pharmacy reviews were available on Resident #12's clinical record.

A review of the clinical record failed to reveal that monthly pharmacy reviews for April 2017 and May 2017 were conducted.

On 6/7/17 at approximately 3:00 p.m., OSM #4 (Other Staff Member) Medical Records person provided a list of residents the pharmacy saw on 4/6/17 and on 5/2/17. Resident #12 was included on the list. However, there was no evidence the pharmacy noted the review in Resident #12's clinical record.

On 6/8/17 at 10:02 a.m., in an interview with OSM #12, the pharmacist, he stated he was not sure if there was a requirement to put a note in the chart.

A review of the facility policy "Medication Regimen Review" documented, "2. The Consultant Pharmacist shall document the Medication Regimen Reviews on the individual resident's "Chronological Record of Medication Regimen Review" form, or in the designated area of the resident's Electronic Health Record (EHR).

On 6/8/17 at approximately 2:00 p.m., the Administrator, ASM (administrative staff member) #1, was made aware of the findings. No further information was provided.

2. The facility staff failed to record Resident #28's weights in the clinical record.

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Resident #28 was admitted to the facility on 2/24/17 and expired at the facility on 6/4/17. The resident was admitted with the diagnoses of but not limited to adult failure to thrive, amputation of left upper and lower extremities, dementia, cerebral infarct, dysphagia, urinary retention, shortness of breath, pain, and cellulitis.

The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 4/3/17. The resident was coded as being cognitively impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident required total care for all activities of daily living and as incontinent of bowel and bladder.

A review of the clinical record revealed an order dated 3/3/17 for weekly weights for 4 weeks, then monthly thereafter if stable. Further review of the clinical record failed to reveal the monthly weights for April and May.

On 6/8/17 at approximately 11:00 a.m., the missing weights were requested from the ASM (administrative staff member) #2, the DON (Director of Nursing).

On 6/8/17 at approximately 1:50 p.m., ASM #2, the DON provided the monthly weight sheet which documented the May 2017 weight but not April. (Note the resident had a room change from one unit to another during this time). She then checked the other unit the resident had been residing on during this time, and stated the "weight girl" (CNA - Certified Nursing Assistant) that obtains and records residents weights was

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not there and she could not locate her weight log for April 2017. These sheets contained weights of multiple residents and therefore were not counted as part of each resident's clinical record.

On 6/8/17 at 1:55 p.m., in an interview with LPN #3 (Licensed Practical Nurse), unit manager, he stated that the weights should be documented in the clinical record.

A policy for accurate documentation was requested on 6/7/17 at approximately 5:45 p.m., at the end of day meeting, but was not provided.

On 6/8/17 at approximately 2:00 p.m., the Administrator was made aware of the findings. No further information was provided.

References:

[1] The usual resting pulse for an adult is 60 to 100 beats per minute. Information obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024325/

3. The facility staff failed to document the administration of Resident # 18's medications on the eMAR (electronic medication administration record).

Resident # 18 was admitted to the facility on 09/02/16 with diagnoses that included but were not limited to: multiple sclerosis (1), hypokalemia (2), anxiety (3), hypertension (4), arthritis and pain

Resident # 18's most recent MDS (minimum data set), a quarterly assessment with an ARD

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(assessment reference date) of 12/06/16, coded Resident # 18 as scoring an 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 18 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) for Resident # 6 dated 06/01/2017 - 06/31/2017 documented, "Gabapentin (5) tablet; 600 mg (milligram); amt (amount) 1 (one) tablet; oral (by mouth); Azathioprine (6) tablet; 50 mg amt: 1 tablet, oral; Ferrous Sulfate (7) tablet; 325 mg (65 mg iron); amt: 1 tablet oral; Folic Acid (8) tablet; 1 mg; amt: 1 tablet oral; Thiamine (9) tablet; 100 mg; amt: 1 tablet oral."

The eMAR (electronic medication administration record) for resident # 18 dated 06/01/2017 through 06/08/17 documented, "Gabapentin (5) tablet; 600 mg (milligram); amt (amount) 1 (one) tablet; oral (by mouth); Azathioprine tablet; 50 mg amt: 1 tablet, oral; Ferrous Sulfate tablet; 325 mg (65 mg iron); amt: 1 tablet oral; Folic Acid tablet; 1 mg; amt: 1 tablet oral; Thiamine tablet; 100 mg; amt: 1 tablet oral." Further review of the eMAR revealed that on 06/01/17 and 06/03/17 the nurse's initials were missing at 7:30 a.m.

On 06/08/17 at 11:55 a.m. a phone interview was conducted with LPN (licensed practical nurse) # 7. When asked if she administered Resident # 18's medications on 06/01/17 and on 06/03/17 at 7:30 a.m. LPN # 7 stated she had worked the 11:00 p.m. to 7:00 a.m. shift on 06/03/17 but not on 06/01/17. LPN # 7 further stated that she did administer Resident # 18's medications. When informed that the eMAR for 06/03/17 did not

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document her initials for the administration of gabapentin, azathioprine, ferrous sulfate, folic acid and thiamine, LPN # 7 stated, "I remember giving the medications I just forgot to document it on the MAR."

On 06/08/17 attempts to contact the nurse who administered Resident # 18's medications on 06/01/17 were unsuccessful.

The facility's policy "Medication Administration" documented, "17. The individual who administers the medication dose records the administration on the resident's MAR immediately after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no care should the individual who administered the medication report off-duty without first recording the administration of any medication. 20. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided on the MAR or on a Master Signature Log."

On 06/08/17 at approximately 12:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

References:

(1) A nervous system disease that affects your brain and spinal cord. It damages the myelin

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sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.

(2) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html.

(6) Used to treat severe rheumatoid arthritis (a

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condition in which the body attacks its own joints, causing pain, swelling, and loss of function) when other medications and treatments have not helped. Azathioprine is in a class of medications called immunosuppressants. It works by decreasing the activity of the body's immune system so it will not attack the transplanted organ or the joints. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682167.html.

(7) Provides the iron needed by the body to produce red blood cells. It is used to treat or prevent iron-deficiency anemia, a condition that occurs when the body has too few red blood cells because of pregnancy, poor diet, excess bleeding, or other medical problems. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682778.html.

(8) A B vitamin. It helps the body make healthy new cells. This information was obtained from the website: https://medlineplus.gov/folicacid.html.

(9) Thiamin is one of the B vitamins. Thiamin (vitamin B1) helps the body's cells change carbohydrates into energy. The main role of carbohydrates is to provide energy for the body, especially the brain and nervous system. This information was obtained from the website: https: https://medlineplus.gov/ency/article/002401.htm.
4. The facility staff failed to ensure Resident #1's clinical record contained an activities care plan.

Resident #1 was admitted to the facility on 10/14/10 and readmitted on 5/1/17. Resident

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#1's diagnoses included but were not limited to: chronic kidney disease, major depressive disorder and anxiety disorder. Resident #1's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 5/15/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of section V of Resident #1's admission MDS assessment with an ARD of 5/8/17 revealed activities as a triggered care area. Section V documented an activities care plan would be developed. Review of Resident #1's current comprehensive care plan revised on 5/31/17 failed to reveal documentation regarding activities.

On 6/7/17 at 7:53 a.m., an interview was conducted with RN (registered nurse) #2 (MDS coordinator). RN #2 stated the activities director was responsible for developing the activities care plan. RN #2 was made aware this surveyor could not find an activities care plan for Resident #1.

On 6/7/17 an interview was conducted with OSM (other staff member) #7 (the activities director). OSM #7 stated the interdisciplinary team looked at Resident #1's care plan on 5/17/17 and an activities care plan was present. OSM #7 stated the activities portion of Resident #1's care plan was discontinued on 5/22/17 and she realized this after this surveyor asked to see the activities portion of the care plan. OSM #7 presented an activities care plan for Resident #1 that was initiated on 10/15/15 but discontinued on 5/22/17. OSM #7 stated she had no idea how the activities care plan was discontinued on 5/22/17 and she did not have access to discontinue care plans.

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F 514	Continued From page 146 OSM #7 stated she just put an activities care plan in the computer system. On 6/7/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the corporate quality assurance clinical nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings. The facility policy titled, "Electronic Health Records" documented, "Care plans are also found under the RAI (resident assessment instrument) tab. The designated nurse is responsible for updating care plans with changes..." No further information was presented prior to exit.	F 514		