STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495280	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER AT LAKE RIDGE	12185 CLIPPER DRIVE LAKE RIDGE, VA 22192

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/5/2018 through 2/8/2018 The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. 1 complaint(s) was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/5/18 through 2/8/18. An extended survey was conducted 2/7/18 through 2/8/18. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. § 483.25 (d). Immediate Jeopardy was identified in the area of Quality of Life at a Scope and Severity Level 4, Isolated, at Accidents and Supervision, which constituted Substandard Quality of Care. After accepting the facility Plan of Correction (POC) for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiencies were assigned a Scope and Severity level of 3, isolated. One complaint was investigated. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 47 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Resident #1 through #398) and three closed record reviews (Resident # 41, 48, and 147).	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as	F 554		3/8/18

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

Electronically Signed | 03/02/2018

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F 554	Continued From page 1 defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed for 1 resident (Resident #44) of 19 residents in the survey sample to ensure the resident was assessed to self administer medications and have physician orders for the medications the resident administered. For Resident #44, a bottle of Tums and and bottle of vitamin B12 was observed on the counter in the bathroom. There was no physician order for the medications and the resident could not describe the reason why she took these medications. The findings included: Resident #44, a 93 year old, was admitted to the facility on 6/24/08. Her diagnoses included constipation, reflux, rheumatoid arthritis, dysphagia, hyperlipidemia, and congestive heart failure. He most recent Minimum Data Set (MDS) assessment was a comprehensive assessment with an assessment reference date of 1/17/18. She was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment and required extensive assistance with her activities of daily living. On 2/5/18 at 2:50 p.m., a bottle of Tums and a bottle of vitamin B12 were observed on the counter in Resident #44's bathroom. The medications were observed on the counter again on 2/6/18 at 11:00 a.m..	F 554	1. Actions taken for the (1) resident identified: -Resident # 44 - the OTC Tums and Vitamin B12 removed from room on 02/07/2018. -The Physician was contacted and orders obtained for the Tums and Vitamin B12. - Resident #44 was re-assessed by way of a Self-Administration Assessment, and it was determined the OTC medications would be administered by the nursing staff and Care Plan was updated. 02/08/2018 2. Identification of other residents who have the potential to be affected: - All residents have the potential to be affected. Resident rooms audited for any unknown bedside medication by nursing administration. No other bedside medications observed. 02/07/2018 - All resident physician orders and care plans reviewed- no active self-administration of medication orders or care plans present. 02/08/2018 3. System changes and measures that will be made: -Review of established policy and procedure for Self Administration Medication and Self Administration Medication Assessment to Nursing Staff by Nurse Educator/designee. -Residents requesting to self-administer medications will be assessed by Licensed Nurse for appropriateness and safety by	

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F 554	Continued From page 2 Resident #44's physician orders were reviewed on 2/6/18. There was no physician order for Tums or vitamin B12. Resident #44's February 2018 Medication Administration Record (MAR) was reviewed. The MAR did not include Tums or the vitamin B12. Resident #44's care plan was reviewed. Included was the Problem " I would like to and have demonstrated my ability to self administer my Nitroglycerin tablets for Chest Pain medication." Start date 1/23/18. The Approaches read "Assess my ability to self-medicate per facility policy. Review Quarterly. Start date 5/16/17" and "Educate me on how to self administer, review name of medication, dose, action, purpose and side effects. Start date 5/16/17." On 2/7/18 at 4:00 p.m., a meeting was held with the Administrator and Assistant Director of Nursing (ADON). At this time, the Administrator was asked if he found Resident #44 to be reliable. He stated no. He was informed that Resident #44 stated that the nursing staff administered her medications at 5:30 a.m. and she did not like to receive medications that early. He was also informed that the Tums and vitamin B12 were observed on the bathroom counter on two occasions. The facility staff were asked to provide documentation that Resident #44 had been screened to self administer medications. On 2/8/18 at 8:30 a.m., the ADON provided the form "Assessment of Self-Administration of Medication" for Resident #44. The "initial review" was dated 10/31/16. The medication "Nitro Tabs" was written on the form and had been crossed	F 554	way of Self Administration Assessment, Licensed nursing staff will obtain a physician□s order for self-administration of medications, and a care plan for administration and storage will be developed for residents who can safely do so per policy. - Presence of active Self Administration of Medications to be reviewed by Licensed Nurse; quarterly, annually, significant change and when nurse observes non-compliance. -MDS Coordinator will audit assessments for self-administration of medications, current physician orders and care plans with each Quarterly and Annual assessment. The Director of Nursing /designee will address concerns. 4. Monitoring mechanisms to assure compliance: - Weekly rounding by Supervisor /designee to include resident environment visualization for unknown bedside medication to ensure compliance. Any unknown medications found in a resident□s room will be removed from their possession and stored by nursing until an assessment completed. The DON and/or designee will report the findings of the inspections, audits, concerns and any corrective actions taken to the QAA committee monthly x 3 months for review and appropriate action. All actions will be completed by 3/08/2018	

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F 554	Continued From page 3	F 554		

out. The word "Tums" was also written on the form. Resident #44 was assessed as "satisfactory" in the category "Appropriate to self administer medications" for the date of 10/31/16.

The review date of 2/15/17 was written on the form. The medication "Nitro" was written on the form and had been crossed out. All pieces of the assessment for the date of 2/15/17 were crossed out. She was not indicated to be satisfactory to self administer medications.

The review date of 1/11/18 was written on the form. The section "Appropriate to self administer medications" was not completed.

It was reviewed with the ADON that there were not physician orders for the Tums or the vitamin B12. When asked how the nurses know when Resident #44 takes the medications and how the medications are documented as having been administered, the ADON stated the resident should tell the nurse.

On 2/8/18 at 8:40 a.m., Resident #44 was interviewed. When asked why she keeps Tums in her bathroom, Resident #44 stated she could not provide a reason. She stated that she just likes to have them. When asked when she is supposed to take them, she stated she takes them sometimes.

At the end of day meeting on 2/8/18, the issue was reviewed with the Administrator, ADON, corporate staff and the MDS coordinator. At this time, the MDS coordinator stated that Resident #44's daughter probably put the medications in the bathroom. It was reviewed that the medications were observed in the room for two

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F 554	Continued From page 4 days and facility staff had not identified that they were there or removed them.	F 554		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to accurately complete an MDS for one resident (Resident #19) in a survey sample of 19 residents. For Resident # 19, the facility staff inaccurately coded the MDS Section H as having an Ostomy. The Findings Included: Resident # 19 was an 88 year old male admitted to the facility on 1/16/2017 with the diagnoses of, but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/27/17. The MDS coded Resident # 19 with a BIMS (Brief Interview for Mental Status) of 11/15 indicating moderate cognitive impairment. Resident # 19 required extensive assistance of one staff person to two staff persons with activities of daily living except required supervision and set up only for eating. He was also coded as having an Ostomy and frequently incontinent of bowel and bladder.	F 641	F641 Accuracy of Assessments MDS Coordinator inadvertently coded the MDS section H of resident #19 as having an Ostomy. Resident #19 was receiving the proper assistance for his continence care by the nursing staff, per care plan. 1. Actions taken for the (1) resident identified: MDS coordinator completed modification of section H0100 for Resident #19 Annual assessments with ARD of 12/27/2017 and resubmitted to CMS on 02/08/2018, which was accepted. 2. Identification of other residents who have the potential to be affected: All current resident assessments reviewed to ensure accuracy of assessment, specifically with section H coding. Completed 02/12/2018. 3. Additional measures shall be put in place to ensure this identified practice will not recur: In service provided to MDS coordinators	3/8/18

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F 641	Continued From page 5 On 2/6/2018 at 9:30 AM, review of the clinical record was conducted. Review of the clinical record revealed the MDS Section H-Bladder and Bowel H0 100 C coded Resident # 19 as having an Ostomy. Review of the Nurses Notes revealed no documentation of an Ostomy. On 2/6/2018 at 10:30 AM, an interview was conducted with Resident # 19 who stated he goes to the bathroom normally. Resident # 19 denied having an Ostomy. On 2/6/2018 at 2:35 PM, an interview was conducted with the RN (Registered Nurse) Supervisor (Registered Nurse A) who stated Resident # 19 did not have an Ostomy. RN A stated he did not know the MDS had been coded with Resident # 19 having an Ostomy. RN A stated he did not have access to the MDS system and the MDS Coordinator was out sick. RN A stated the coding must have been a mistake. On 2/6/2018 at 2:37 PM, an interview was conducted with LPN (Licensed Practical Nurse) A who stated he regularly cared for Resident # 19 and was sure he did not have an Ostomy. On 2/6/2018 at 2:40 PM, an interview was conducted with the Assistant Director of Nursing who stated Resident # 19 did not have an Ostomy. The Assistant Director of Nursing stated the expectation was that the MDS should be accurate. Guidance from CMS"s RAI instructions: CMS ' s RAI Version 3.0 Manual CH 3: MDS	F 641	on the importance of accuracy of coding on all MDS assessments- completed 02/12/2018. 4. Monitoring mechanisms to assure compliance: Interdisciplinary team will audit a random sample of three MDS assessments per month x 3 months to determine accuracy of coding. The results of the audits will be reported, reviewed, and trended for compliance thru the QAA committee monthly x 3 months for review and appropriate action. All actions completed by 03/08/18	

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F 641	Continued From page 6	F 641		

Items [H]
May 2013 Page H-2
H0100: Appliances (cont.)
· Care planning should be based on an assessment and
evaluation of the resident ' s history, physical examination, physician orders, progress notes, nurses '
notes and flow sheets, pharmacy and lab reports, voiding
history, resident ' s overall condition, risk factors and
information about the resident ' s continence status,
catheter status, environmental factors related to continence programs, and the resident ' s response to
catheter/continence services.
Steps for Assessment
1. Examine the resident to note the presence of any urinary or
bowel appliances.
2. Review the medical record, including bladder and bowel
records, for documentation of current or past use of urinary
or bowel appliances.
Coding Instructions
Check next to each appliance that was used at any time in the
past 7 days. Select none of the above if none of the appliances
A-D were used in the past 7 days.
· H0100A, indwelling catheter (including suprapubic
catheter and nephrostomy tube)
· H0100B, external catheter
· H0100C, ostomy (including urostomy, ileostomy, and

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F 641	Continued From page 7	F 641		

colostomy)
· H0100D, intermittent catheterization
· H0100Z, none of the above
Coding Tips and Special Populations
· Suprapubic catheters and nephrostomy tubes should be
coded as an indwelling catheter (H0100A) only and not
as an ostomy (H0100C).
· Condom catheters (males) and external urinary pouches
(females) are often used intermittently or at night only; these should be coded as external catheters.
· Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
· Do not include one time catheterization for urine specimen during look back period as intermittent catheterization.
DEFINITIONS
EXTERNAL CATHETER
Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.
OSTOMY
Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.
UROSTOMY
A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and

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F 641	Continued From page 8 urethra is not possible, e.g., after extensive surgery or in case of obstruction. ILEOSTOMY A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin. COLOSTOMY A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall. https://www.aanac.org/docs/mds-3.0-rai-users-manual/11123_mds_3-0_chapter_3_-_section_h_v1-12.pdf?sfvrsn=6 The facility Administrator, Assistant Director of Nursing, and corporate manager were informed of the failure of the staff to complete Section H0 100 accurately for an annual MDS with the ARD of 12/27/2017 during the end of day debriefing on 2/7/2018. On 2/8/2018 at 11:30 AM, an interview was conducted with the MDS Coordinator (RN C) who stated she had submitted a modification to the MDS to correct section H0 100. RN C stated the information about the Ostomy had transferred from incorrect information submitted by the Certified Nursing Assistants. RN C stated "I missed it. He does not have an Ostomy." No further information was provided.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		3/8/18

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F 658	Continued From page 9 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure professional standards for three residents (Residents # 397, 19 and 398) in a survey sample of 19 residents. (The staff failed to ensure and implement a method of disposition of written prescriptions for narcotics was followed to prevent potential diversion of controlled drugs.) 1. For Resident # 397, the facility staff failed to send a hard copy script dated 12/30/2017 for Oxycodone 5 milligrams to the Pharmacy. 2. For Resident # 19, the facility staff failed to send a hard copy script dated 1/16/2017 for Oxycodone 5 milligrams to the Pharmacy. 3. For Resident # 398, the facility staff failed to send a hard copy script dated 5/24/2017 for Norco 5/325 to the Pharmacy. Findings Included: 1. For Resident # 397, the facility staff failed to send a hard copy script dated 12/30/2017 for Oxycodone 5 milligrams to the Pharmacy. Resident # 397 was a 93 year old female admitted to the facility originally on 4/21/2015 and readmitted on 12/30/2017 with the diagnoses of,	F 658	F 658-Services Provided Meet Professional Standards: staff failed to ensure and implement a method of disposition of written prescriptions for narcotics was followed to prevent potential diversion of controlled drugs. 1. Actions taken for the resident identified: * Resident # 397, 19, and 398 were not negatively affected by the alleged deficiency. * Resident # 397, 19, and 398 received medication per physician□s orders -The identified hard copy narcotic prescriptions for Residents # 397, 19 and 398 were returned to pharmacy. -In-service provided to Licensed Nurses on established policy review of New Orders for Scheduled II, III, and IV Controlled Substances. 2. Identification of other residents who have the potential to be affected: All Resident charts were audited for hard copy narcotic prescriptions any hard copy narcotic prescriptions were returned to the pharmacy. Completed 02/07/2018 3. Additional measures shall be put in place to ensure this identified practice will	

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F 658	Continued From page 10 but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease. The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 3 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment. Resident # 397 required extensive assistance of one staff person to two staff persons with activities of daily living except required total assistance of one staff person for bathing and was coded for supervision and set up only for eating; She was also coded as frequently incontinent of bowel and bladder. On 2/6/2018 at 9:30 AM, review of the clinical record was conducted. Review of the clinical record revealed a hard copy of a written prescription for a narcotic dated 12/30/2017 from the hospital.. There was a hard script dated 12/30/2017 for Oxycodone (Roxicodone) 5 milligrams immediate release tablet, take 0.5 (2.5 milligrams) total by mouth every 4 hours as needed for pain. Route: Oral. Quantity 70 (Seventy) tablets. There was no line drawn through the prescription to indicate the prescription had been filled. Review of the Physicians Orders Summary for 2/7/ 2018 revealed an order written on 1/27/2018 Oxycodone 5 milligrams tablet, take 0.5 total by mouth every 4 hours as needed for pain. Route: Oral. On 2/7/2018 at 2:45 PM, an interview was conducted with the RN (Registered Nurse)	F 658	not recur - Licensed Nurses after faxing Schedule II, III, or IV Controlled Substance prescription to the pharmacy will deface the hard copy controlled substance prescription and per policy and place, the defaced prescription into the Prescription Return Bag located in the Nursing Supervisor office. - Supervisors will log each prescription returned to pharmacy in the Controlled Substance Prescription Return log. - In-service by the Consultant Pharmacist/designee shall be provided to and required of licensed Nursing staff on the Medication Policy and procedures for New Orders for Scheduled II, III and IV Controlled Substances to include Delivery and Receipt of Routine/Emergency/STAT Deliveries -Education and training on Medication policy and procedures for New Orders for Scheduled II, III, and IV Controlled Substances to include Delivery and Receipt of Routine/Emergency/STAT Deliveries shall be included in orientation for newly hired Licensed Nursing staff. 4. Monitoring mechanisms to assure compliance: -Nursing administration or designee will conduct weekly audits of physician orders for Controlled Substance orders cross checking with Controlled Substance Return log to ensure hard copy prescriptions have been sent to the pharmacy. -Audits will be conducted for three months and results turned in to QAA	

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F 658	Continued From page 11 Supervisor (RN A) who stated prescriptions for narcotics should be faxed to the Pharmacy. RN A stated a copy of the prescription should be left inside the chart, with a line drawn through the prescription. On 2/7/2018 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated after faxing a copy, the hard scripts should be sent to the Pharmacy and a copy should be left in the chart. On 2/7/2018 at 3:30 PM, an interview was conducted via the telephone with the Consultant Pharmacist who stated the facility had a procedure in place to handle prescriptions for narcotic. The Consultant Pharmacist (Admin F) stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record and the actual prescription should be sent to the Pharmacy. There was a poor telephone connection and the Pharmacist stated she was at another facility at that moment but would call the surveyor the next morning at 9 AM from a different telephone to clarify. During the end of day debriefing on 2/7/2018 at 4:15 PM, the facility Administrator, Assistant Director of Nursing (Admin B) and the corporate representative were informed of the findings. Admin B stated the professional guidance was provided by Lippincott. On 2/8/2018 at 8:55 AM, the Pharmacy Consultant (Admin F) came to the conference room to talk with the surveyor. Admin F apologized about the telephone connection on the previous day but stated she decided to come to	F 658	committee for review and appropriate action. 5. All actions will be completed by 3-8-2018	

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the facility to clarify any concerns. Admin F stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record, a line should be drawn through the copy of the prescription and the actual prescription should be sent to the Pharmacy. Admin F stated the Pharmacy delivers to the facility twice a day. Admin F stated her supervisor, the Pharmacist in Charge, wanted to talk with the surveyor about the procedures regarding narcotics. Admin F reviewed Resident # 397's clinical record and saw the hard script for Oxycodone. Admin F stated the prescription should have been sent to the Pharmacy by facility staff. Admin F agreed that the prescription was not secure as filed in the clinical record.

On 2/8/2018 at 9:06 AM, a telephone interview was conducted with the Pharmacist in charge (Admin G) stated the facility was "supposed to forward the hard copies of narcotics to the Pharmacy in a bag and that the Pharmacy delivery person comes twice a day" to the facility.

During the end of day debriefing on 2/8/2018, the facility Administrator, Assistant Director of Nursing and Corporate Manager were informed of the failure of the staff to ensure the implementation of a method of safekeeping of hard scripts for narcotics. The nursing staff did not forward the hard copy of the narcotic prescription to the Pharmacy and the Pharmacy did not make sure it received the hard copy of the narcotic prescription. There was the potential of diversion of controlled drugs. There was the potential of diversion of controlled drugs.

No further information was provided.

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2. For Resident # 19, the facility staff failed to send a hard copy script dated 1/16/2017 for Oxycodone 5 milligrams to the Pharmacy.

Resident # 19 was a 88 year old male admitted to the facility on 1/16/2017 with the diagnoses of, but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/27/17. The MDS coded Resident # 19 with a BIMS (Brief Interview for Mental Status) of 11/15 indicating moderate cognitive impairment; Resident # 19 required extensive assistance of one staff person to two staff persons with activities of daily living except required supervision and set up only for eating; He was also coded as having an Ostomy and frequently incontinent of bowel and bladder.

On 2/6/2018 at 9:30 AM, review of the clinical record was conducted.

Review of the clinical record revealed a hard copy of a written prescription dated 1/16/17 for Oxycodone 5 milligrams one tablet oral every 4 hours as needed for pain Dispense/supply 30 tablets with no refills.

Review of the signed Physicians Order Summary dated 1/10/2018 revealed no current order for Oxycodone.

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On 2/7/2018 at 2:45 PM, an interview was conducted with the RN (Registered Nurse) Supervisor (RN A) who stated prescriptions for narcotics should be faxed to the Pharmacy. RN A stated a copy of the prescription should be left inside the chart, with a line drawn through the prescription.

On 2/7/2018 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated after faxing a copy, the hard scripts should be sent to the Pharmacy and a copy should be left in the chart.

On 2/7/2018 at 3:30 PM, an interview was conducted via the telephone with the Consultant Pharmacist who stated the facility had a procedure in place to handle prescriptions for narcotic. The Consultant Pharmacist (Admin F) stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record and the actual prescription should be sent to the Pharmacy. There was a poor telephone connection and the Pharmacist stated she was at another facility at that moment but would call the surveyor the next morning at 9 AM from a different telephone to clarify.

During the end of day debriefing on 2/7/2018 at 4:15 PM, the facility Administrator, Assistant Director of Nursing (Admin B) and the corporate representative were informed of the findings. Admin B stated the professional guidance was provided by Lippincott.

On 2/8/2018 at 8:55 AM, the Pharmacy

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Consultant (Admin F) came to the conference room to talk with the surveyor. Admin F apologized about the telephone connection on the previous day but stated she decided to come to the facility to clarify any concerns. Admin F stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record, a line should be drawn through the copy of the prescription and the actual prescription should be sent to the Pharmacy. Admin F stated the Pharmacy delivers to the facility twice a day. Admin F stated her supervisor, the Pharmacist in Charge, wanted to talk with the surveyor about the procedures regarding narcotics. Admin F reviewed the Resident # 19's clinical record and saw the hard script for Oxycodone. Admin F stated the prescription should have been sent to the Pharmacy by facility staff. Admin F agreed that the prescription was not secure as filed in the clinical record.

On 2/8/2018 at 9:06 AM, a telephone interview was conducted with the Pharmacist in charge (Admin G) stated the facility was "supposed to forward the hard copies of narcotics to the Pharmacy in a bag and that the Pharmacy delivery person comes twice a day" to the facility.

Per the surveyor's request, Admin B provided a copy of the pharmacy delivery summary. Review of the Pharmacy Proof of Delivery Shipment Summary revealed Oxycodone 5 milligrams tablets quantity 30 was filled on 1/16/2017.
Admin B stated the nursing staff should have faxed a copy of the prescription, made a copy for the chart with a line drawn through it and forward the hard copy to the Pharmacy in the bag.

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During the end of day debriefing on 2/8/2018, the facility Administrator, Assistant Director of Nursing and Corporate Manager were informed of the failure of the staff to ensure the implementation of a method of safekeeping of hard scripts for narcotics. The nursing staff did not forward the hard copy of the narcotic prescription to the Pharmacy and the Pharmacy did not make sure it received the hard copy of the narcotic prescription. There was the potential of diversion of controlled drugs. There was the potential of diversion of controlled drugs.

No further information was provided.

3. Resident # 398 was a 75 year old female admitted to the facility on 5/11/2017 with the diagnoses of, but not limited to, Fracture of Neck of Left Femur, History of Falling, Chronic Obstructive Pulmonary Disease, Dementia, Hypothyroidism and Hyperlipidemia.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 398 with a BIMS (Brief Interview for Mental Status) of 10/15 indicating moderate cognitive impairment; Resident # 398 required extensive assistance of one staff person to two staff persons with activities of daily living except required supervision and set up only for eating; She was also coded as frequently incontinent of bowel and bladder. Resident # 398 was coded as requiring oxygen therapy.

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On 2/6/2018 at 9:30 AM, review of the clinical record was conducted.

On the inside of the clinical record were plastic sleeves covering several sheets of papers. Under one plastic sleeve that included a document about Code Status, there were several hand written prescriptions. One of the prescriptions was a hard copy of a written prescription for a narcotic dated 5/24/17 for Norco 5/325 one tablet by mouth every 4 hours as needed Quantity 100. There were no marks on the prescription indicating the disposition of whether the prescription had been filled or was no longer valid.

There was no indication the prescription had ever been filled.

On 2/7/2018 at 2:45 PM, an interview was conducted with the RN (Registered Nurse) Supervisor (RN A) who stated prescriptions for narcotics should be faxed to the Pharmacy. RN A stated a copy of the prescription should be left inside the chart, with a line drawn through the prescription.

On 2/7/2018 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated after faxing a copy, the hard scripts should be sent to the Pharmacy and a copy should be left in the chart.

After reviewing the record, the Assistant Director of Nursing (Admin B) stated Resident # 398 was supposed to be discharged to home in May 2017 and the prescriptions were supposed to be given to her at discharge. Admin B stated the staff should have forwarded the prescription for the

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narcotic to the pharmacy or marked as voided if it was not to be filled. Admin B agreed that the prescription was not secure in the clinical record.

On 2/8/2018 at 8:55 AM, the Pharmacy Consultant (Admin F) came to the conference room to talk with the surveyor. Admin F apologized about the telephone connection on the previous day but stated she decided to come to the facility to clarify any concerns. Admin F stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record, a line should be drawn through the copy of the prescription and the actual prescription should be sent to the Pharmacy. Admin F stated the Pharmacy delivers to the facility twice a day. Admin F stated her supervisor, the Pharmacist in Charge, wanted to talk with the surveyor about the procedures regarding narcotics. Admin F reviewed the Resident # 398's clinical record and saw the hard script for Norco. Admin F stated the prescription should have been sent to the Pharmacy by facility staff.
Admin F agreed that the prescription was not secure as filed in the clinical record.

On 2/8/2018 at 9:06 AM, a telephone interview was conducted with the Pharmacist in charge (Admin G) stated the facility was "supposed to forward the hard copies of narcotics to the Pharmacy in a bag and that the Pharmacy delivery person comes twice a day" to the facility.

During the end of day debriefing on 2/8/2018, the facility Administrator, Assistant Director of Nursing and Corporate Manager were informed of the failure of the staff to ensure the

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F 658	Continued From page 19 implementation of a method of safekeeping of hard scripts for narcotics. The nursing staff did not forward the hard copy of the narcotic prescription to the Pharmacy and the Pharmacy did not make sure it received the hard copy of the narcotic prescription. There was the potential of diversion of controlled drugs. There was the potential of diversion of controlled drugs. No further information was provided.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, clinical record and facility documentation review, the facility staff failed to serve hot liquids at a safe temperature to Resident # 397, resulting in Immediate Jeopardy. The facility also failed to serve coffee at a safe temperature for Resident # 21, resulting in harm (second degree burns). 1. The staff allowed unrestricted and unsupervised access to a coffee/hot water machine producing coffee at 177 degrees F (Fahrenheit). Resident #397 was served this coffee immediately after the CNA (certified nursing assistant, Employee A) poured her the coffle.	F 689	It is the intent of this facility for all residents to remain free of injury from hot liquids. 1. Actions taken: -Coffee Machine was immediately removed from the South dining hall- Completed 2-6-18 - A Hot Liquids Risk Assessment was completed for Identified Resident #21. Recommendation by IDT was made for Resident to use a coffee cup with a secure lid to minimize recurrence and promote resident safety. Resident agreed to use coffee cup with a secure lid for	3/8/18

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F 689	Continued From page 20 2. Resident #21 sustained second degree burns from spilling hot coffee on herself. There were no temperatures for hot liquids documented. The resident was not assessed for safety with hot liquids prior to or after the burn. The findings included: 1. Resident # 397 was a 93 year old female admitted to the facility originally on 4/21/2015 and readmitted on 12/30/2017 with the diagnoses of, but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease. The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 397 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment. Resident # 397 required extensive assistance of one staff person to two staff persons with activities of daily living except required total assistance of one staff person for bathing and was coded for supervision and set up only for eating. During tour on 2/5/18 at 2:48 PM, food /temperature logs were reviewed. No hot beverage temperatures were taken. Kitchen manager stated that it was the "nursing staff's responsibility to take the coffee temperatures." He said that there were currently no residents who were using special cups with two handles. He further stated that no residents had ever been burned. 02/06/18 4:40 PM: Pantry area near kitchen	F 689	safety. Care plan was revised to include recommendation of coffee cup with a secure lid for safety. Completed 02/06/18 2. Other residents having the potential to be affected by this alleged deficient practice: An initial Hot Liquids Risk Assessment was completed for all residents to identify anyone who would be at risk for spillage and/or injury from coffee/hot liquids. Any identified to be at risk were referred to the Interdisciplinary team (IDT) for recommendations to minimize their risk for injury and promote resident safety. Completed 02/07/18 3. Measures put into place/ systemic: -Facility Staff in-serviced in regards to resident safety with hot liquids and Policy and Procedure for Hot Liquids Risk Assessment by Nurse Educator/designee by 02/07/18. Action initiated and ongoing. - All residents will be assessed for risk of use of hot liquids by licensed nurse or therapist to minimize their risk for injury and promote resident safety with all new admissions, quarterly, significant change and re-assessed if the resident experiences injury from spilled hot liquids. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur: Dining Services /designee will conduct daily audits of hot liquid temperature prior to leaving kitchen. Audits will be conducted for three months and results turned in to QAA committee	

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F 689	Continued From page 21 (south dining room) has two entryways into the pantry (no doors). A coffee maker/hot water machine was on the counter at waist level, accessible by w/c (wheelchair) residents. On palpation, the water was extremely hot with small bubbles and steam evident, painful to touch. Styrofoam cups were on the counter next to the machine. No residents were observed near the pantry at this time. 02/06/18 5:40 PM: A small steam table on the same counter as the coffee maker contained hot soup. The dietary supervisor checked the temperature of the soup, which was 155 degrees Fahrenheit (F). Coffee temperature was checked as well with the temperature of the coffee at 177 degrees F, which was served to Resident #397 immediately by a CNA (certified nursing assistant- employee A). On 2/7/18 at approximately 3:00 PM, Employee (E) was asked for the manufacturer's guidelines for the coffee/hot water machine. The specifications for this machine read as follows (page 43): "Internal boiler temperature range, adjustable between 83 degrees Celsius- 97 degrees Celsius (181.4 to 206 degrees Fahrenheit)." The Burn Foundation gives the following information on burns: "Coffee, tea, soup and hot tap water can be hot enough to cause serious burn injury: Hot Water Causes Third Degree Burns ... ...in 1 second at 156º ...in 2 seconds at 149º ...in 5 seconds at 140º ...in 15 seconds at 133º. "	F 689	for review and appropriate action. 5. All actions will be completed by 3-8-2018	

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2/6/18: Review of the care plan for Resident #397, dated 1/9/18, read as follows: "I require extensive assistance with my bathing, grooming, dressing, mobility and eating related to impaired cognition, decreased strength /mobility."

2. Resident #21 sustained a second degree burn from spilling hot coffee on herself on 1/28/18. There were no temperatures for hot liquids documented. The resident was not assessed for safety with hot liquids prior to and after the burn and the facility did not take action to correct the practice of monitoring and adjusting the serving of hot liquids.

Resident #21 was admitted to the facility on 5/4/16. Diagnoses included congestive heart failure, diabetes type 2, high blood pressure and depression.

Resident #21's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/3/18 was coded as a significant change in status assessment. The resident was coded as having a BIMS (brief interview of mental status) of "9" out of a possible 15, or moderate cognitive impairment. Resident #21 was also coded as requiring extensive assistance of one staff member to perform activities of daily living (ADL's), but requires supervision of one staff member for eating.

On 2/6/18 at approximately 3:00 PM, Resident #21 was observed in her room. She refused an interview.

On 2/6/18, review of the clinical record review rev

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revealed on 1/28/18, the resident had sustained a second degree burn on her abdomen from spilling hot coffee during her breakfast. Treatment to the burn was ordered. The facility documented the resident had no pain on the day of the burns and thereafter. The resident ate her meals in the South dining Room where the coffee container was located. She stated, "It could happen to anybody."

On 1/31/18, the resident's primary physician noted the following: "Patient had poured hot coffee on her abdomen on 1/29/18. Silvadene (burn ointment) started empirically and skin prep on blister every day."

On 1/31/18, the skin evaluation form noted the following measurements: "2.4 cm (centimeters) with a width of 8 cm."

Johns Hopkins Medicine describes second degree burns as:
"Second-degree (partial thickness) burns
Second-degree burns involve the epidermis and part of the dermis layer of skin. The burn site appears red, blistered, and may be swollen and painful."

Review of the temperature logs the day of the incident revealed oatmeal/grits temperature was 170 degrees. There were no temperatures of hot liquids such as coffee and tea.

02/06/18 03:28 PM: Interview with Resident #21's son who was present in room. Resident had earlier stated she did not like to talk or be asked questions. The son stated that the facility had called him about the burn. He stated, "She had a blister or two, which was painful for a brief

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period." He went on to state that therapy was looking at a cup that would be appropriate for her. Review of the wound note dated 1/28/18 documented an area of 2.4 cm (centimeters) by 8.0 cm.

02/06/18 5:30 PM: Resident #21 was at the dining room (DR) (South) table with milk and cold water in regular mugs. She had no liquids with her meal.

2/6/18: 5:50 PM: notified supervisor of possible IJ.

2/6/18: 6:00 PM: Called office and notified supervisors and Division Director of possible IJ Immediate jeopardy). At 6:15 PM, the office advised to get more information form the facility.

2/6/18: 6:20 PM: The facility Administrator and acting DON were notified of needed information. The Administrator stated the facility had a mock survey completed and had identified there was no policy for hot liquids and had also reviewed this on their QA (quality assurance meeting) monthly meeting on 1/26/18.

2/6/18: 6:45 PM: Information received from facility. The facility was unable to demonstrate hot liquid safety assessments were completed for Resident #21 or all other residents at risk after Resident #21 was burned. The Program Manager presented facility wide assessments completed on 1/10 and 1/11/18 (prior to the burn) which she stated, "We assessed residents for use of adaptive equipment correctly." She went on to state that the screen was "not specifically for hot liquid" safety. In addition, the facility staff

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was informed that the continued lack of documentation of hot liquid temperatures and the unrestricted use of the hot coffee/hot water machine may constitute IJ (immediate jeopardy).

2/6/18: 7:30 PM: Information reviewed, called supervisor, agreed with IJ
2/6/18: 7:35 PM: Administrator and team notified to report to conference room.
2/6/18: 7:38 PM: Administrator and team notified of IJ. POC (plan of correction) requested.
2/6/18: 8:30 PM, POC reviewed and accepted. The coffee/hot water machine was removed from service (IJ
abated).

Review of the POC revealed:
1. The identified resident received a hot liquid assessment. Resident has agreed to use coffee cup with a secure lid for safety. Care plan was updated. All coffee machines were immediately removed from the units. (2/6/18)
2. All residents will receive a hot liquids assessment by 2/7/18.
3. Facility staff will be inserviced on hot liquids policy and procedure by 2/7/18.
4. Dining Services/designee will conduct daily audits to ensure proper temperature of 165-170 hot liquids prior to leaving kitchen. Audits will be conducted for three months and results turned in to QAA committee for review and appropriate action.
5. All actions will be completed by 2/7/18.

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On 2/6/18 at 4:20 p.m., interviews were conducted with the dietary staff in the main kitchen. The Kitchen Manager (Employee B) was asked about the service of hot beverages. She stated that no hot liquids were served on the meal trays that leave the kitchen. She stated that hot coffee goes into a carafe and is transported on top of the carts that are delivered to the memory unit and the open dining area where the residents requiring assistance eat. The pantry at the South dining area had a machine that dispensed hot liquids. In summary, two of the three dining areas were provided hot liquids in carafes from the main kitchen.

Temperatures of the hot liquids in the carafes prepared for the units in the main kitchen were not observed to be taken.

On 2/6/18 at 4:30 p.m. three carafes (hot water, coffee and decaf coffee) were observed in the pantry area of the memory care dining area. Diet Supervisor (Employee C) entered the dining area and took the temperatures of all three liquids using a regular thermometer (not digital). Hot water= 130 degrees Fahrenheit (F), coffee= 118

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degrees F, decaf= 110 degrees F.

On 2/6/18 at 4:40 p.m. no carafes of hot liquid were observed in the south dining hall pantry. This pantry had an automatic hot liquid dispensing machine that could dispense hot water, coffee and decaf coffee. Employee C entered the pantry and took the temperature of the broccoli cheddar soup. The temperature measured 155 degrees F. Employee C was not observed to take the temperatures of the hot liquids available from the automatic dispensing machine.

Observations continued in the south dining area. At 5:10 p.m., the dietary aide (Employee A) dispensed a cup of hot liquid from the machine. She added packets of a powdered substance and stirred the liquid for approximately 2- 3 minutes. She served the hot beverage to a resident in the dining room. Employee C was in the dining room at this time and he was asked to take the temperature of the hot beverage just served by Employee A. The temperature was 134 F. Employee A was asked if she ever took the temperature of the hot liquids or soups that she served. Employee A stated no. Employee A was asked if she had a thermometer in the pantry. She stated no.

On 2/6/18 at 5:35 p.m., a second Diet Supervisor (Employee D) walked into the south dining area. She was asked to take the temperature of three items in the pantry. The mighty shake, a cold nutritional supplement, was 41.9 degrees F. The broccoli cheddar soup was 155 degrees F. Lastly, Employee D was asked to fill a cup with coffee from the automatic hot liquid dispenser and take the temperature. At this time, Employee

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A (diet aide) walked up to the machine to fill a cup of decaf coffee for a resident. Employee D took the cup of decaf coffee from Employee A and told Employee A that she would need to fill another cup. Employee D took the temperature of the cup of decaf coffee with a digital thermometer. The temperature measured 177 degrees F.

Immediately after the temperature was taken, Employee A, in the presence of Employee D, dispensed a new cup of decaf coffee. Employee A put the cup on a saucer. She took two creamers out of the refrigerator and put them on the saucer. The coffee was steaming. The cup of coffee did not have a lid. She then served the cup of decaf coffee to Resident #397 who was seated at the table.

Resident # 397 was a 93 year old female admitted to the facility originally on 4/21/2015 and readmitted on 12/30/2017 with the diagnoses of, but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 3 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 397 required extensive assistance of one staff person to two staff persons with activities of daily living except required total assistance of one staff person for bathing and was coded for supervision and set up only for eating.

On 2/6/18 at 6:45 p.m. the Administrator and Director of Therapy (Employee F) were

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interviewed regarding the plan put into place after Resident #21 was burned by the hot coffee. The Administrator stated that all residents were screened by therapy. The Director of Therapy stated that the residents were screened for the need of adaptive equipment during self feeding. She stated that all residents were screened to use a cup without a lid. When asked if the screening she completed was a hot liquid assessment, the Director of Therapy stated no. When asked if her screen was to assess the physical ability versus the cognitive ability of the residents to drink hot liquids, the Director of Therapy stated that her assessment was of physical ability only. The assessments were reviewed by the survey team. They were dated 1/10/18 to 1/11/18, prior to Resident #21's burn.

The Administrator also stated that after Resident #21 was burned on 1/28/18, the dietary staff began to monitor the temperatures of the hot beverages served. The Administrator was asked to provide the coffee temperature logs. This surveyor and the Administrator entered the main kitchen on 2/6/18 at 7:05 p.m. to review the hot beverage temperature logs. The Administrator asked the Kitchen Manager (Employee B) for the logs. She stated that the log for the dinner meal that evening had not been returned from the floor yet. She was asked to provide the log and all of the logs since 1/28/18. Employee B stated that the dietary department did not have temperature logs from 1/28/18 because they just started taking the temperatures of hot liquids on 2/5/18 after the survey team asked about hot liquid temperatures during the initial tour of the kitchen. She was asked to provide the temperature log for the dinner meal on 2/6/18 once it was located.

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F 689	Continued From page 30 As of the conclusion of the survey on 2/8/18, the temperature log for the 2/6/18 dinner meal was not provided. On 2/6/18 at 7:10 p.m., the Director of Dining Services stated that the machine in the south dining pantry dispensed liquids at 160-165 degrees F. He was informed that the machine dispensed a cup of coffee measuring 177 degrees F during the dinner meal service that evening. No temperature logs were provided as documentation that temperatures of the hot beverages served from the machine had been monitored. The Director of Dining Services also stated that the dietary aides were supposed to let the hot liquids sit for three minutes once poured to let the liquid cool down so it is not too hot when served. When asked how the facility defined "too hot", the Dining Services Director stated 155 degrees F.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, the facility staff failed to to administer oxygen in a manner to prevent the spread of infection for one	F 695	1. Actions taken for the (1) resident identified: Identified Resident #398 physician orders reviewed; Administer Oxygen at 2 liters	3/8/18

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F 695	Continued From page 31 Resident (Resident # 398) in a survey sample of 19 Residents. For Resident # 398, the oxygen tubing was not changed from 1/27/18 until 2/6/2018. The findings included: Resident # 398 was a 75 year old female admitted to the facility on 5/11/2017 with the diagnoses of, but not limited to, Fracture of Neck of Left Femur, History of Falling, Chronic Obstructive Pulmonary Disease, Dementia, Hypothyroidism and Hyperlipidemia. The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 398 with a BIMS (Brief Interview for Mental Status) of 10/15 indicating moderate cognitive impairment; Resident # 398 required extensive assistance of one staff person to two staff persons with activities of daily living except required supervision and set up only for eating. She was also coded as frequently incontinent of bowel and bladder. Resident # 398 was coded as requiring oxygen therapy. On 2/6/2018 at 9:30 AM, review of the clinical record was conducted. During the initial tour on 2/5/2018 at 2:30 PM, Resident # 398 was not in her room. A red "Oxygen in Use" sign was noted on the outside of the door. An oxygen concentrator was located on the right side of the bed. The oxygen tubing and bag connected to an oxygen concentrator	F 695	via N/C for SOB or oxygen saturation below 90%. Per review of nursing documentation resident has not required oxygen in past two months. -Oxygen tubing dated for 01/27/2018 on identified resident #21 immediately replaced on 02/06/2018 with new tubing available for resident utilization PRN. 2. Other residents having the potential to be affected by this alleged deficient practice. All residents in the facility receiving oxygen have the potential to be affected by the alleged deficient practice All Residents with Oxygen were audited and tubing was dated properly. 02/06/2018 3. Measures put into place/ systemic Nursing staff have been in-serviced on facility Oxygen policy and procedures by Nurse Educator/ designee. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur. -Nursing Supervisor/designee will conduct weekly audits to ensure all residents with oxygen have tubing changed and dated properly. -Audits will be conducted for three months shall be provided to the Assistant Director of Nursing /designee for review and results turned in to QAA committee for review and appropriate action. 5. All actions will be completed by	

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were dated 1/27/2018 -11-7 shift.

As the initial tour continued, Resident # 398 was observed 2/5/18 at 3:21 p.m. sitting in a wheelchair in the Activity Room. Resident # 398 was participating in the activity and did not have any oxygen on.

Review of the Physicians Orders revealed the following orders for oxygen therapy:
9/30/2017 for Oxygen at 2 Liters per minute via nasal cannula PRN (as needed) for Shortness of Breath..
9/30/2017 Check oxygen saturations every shift. Notify the MD (Medical Doctor) if below 90 % room air, give oxygen- every shift.
11/19/2017 Change oxygen tubing and bag weekly 11-7 (Saturday)- every week
12/3/2017 Change oxygen concentrator filter weekly 11-7 (Saturday)
12/3/2017 Change oxygen humidifier water weekly 11-7 (Saturday)and PRN -Every Week as needed

Resident # 398 was observed 2/6/18 at 10:22 a.m. The bag and tubing from the oxygen concentrator was dated 1/27/18.

Review of the facility policy entitled "Oxygen Administration" did not include the frequency of changing tubing once the therapy has been initiated. The policy also did not include that the tubing should be dated.

On 2/6/2018 at 3:20 PM, the facility Administrator and Nursing Supervisor observed the date on the oxygen tubing and bag was dated 1/27/2018. The Administrator stated the tubing should have

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F 695	Continued From page 33 been changed on 2/3/17 when all of the oxygen equipment was scheduled to be changed. The Registered Nurse (RN) Supervisor (RN A) stated the standard for the facility was for all of the oxygen tubing to be changed weekly on 11-7 shift. RN A stated Resident # 398 had an order for PRN (as needed) use of oxygen. RN A opened the outside zip lock bag dated 1/27/2018 and noted the tubing bag was open with a date of 1/27/2018 on the end of the tubing. RN A stated the staff should not have opened the bag of tubing. RN A stated the facility staff should change the tubing weekly and staff should check the date on the tubing prior to using it to make sure it is not longer than a week. When interviewed 2/7/18 at 4:55 p.m., the Assistant Director of Nursing (Admin B) stated oxygen tubing should be changed weekly. During the end of day debriefing on 2/7/2018, the Administrator, Corporate and Assistant Director of Nursing were informed of the failure of the staff to change the oxygen tubing weekly for Resident # 398. No further information was provided.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		3/8/18

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F 755	Continued From page 34 a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure professional standards for three residents (Residents # 397, 19 and 398) in a survey sample of 19 residents. (Failed to ensure and implement a method of disposition of written prescriptions for narcotics was followed to prevent potential diversion of controlled drugs.) 1. For Resident # 397, the facility staff failed to send a hard copy script dated 12/30/2017 for Oxycodone 5 milligrams to the Pharmacy.	F 755	1. Actions taken for the (1) resident identified: * Resident # 397, 19, and 398 were not negatively affected by the alleged deficiency. * Resident # 397, 19, and 398 received medication per physician□s orders -The identified hard copy narcotic prescriptions for Residents # 397, 19 and 398 were returned to pharmacy. -Policy and procedure for Medication Policy and procedures for New Orders for	

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F 755	Continued From page 35 2. For Resident # 19, the facility staff failed to send a hard copy script dated 1/16/2017 for Oxycodone 5 milligrams to the Pharmacy. 3. For Resident # 398, the facility staff failed to send a hard copy script dated 5/24/2017 for Norco 5/325 to the Pharmacy. Findings Included: 1. For Resident # 397, the facility staff failed to send a hard copy script dated 12/30/2017 for Oxycodone 5 milligrams to the Pharmacy. Resident # 397 was a 93 year old female admitted to the facility originally on 4/21/2015 and readmitted on 12/30/2017 with the diagnoses of, but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease. The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 3 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 397 required extensive assistance of one staff person to two staff persons with activities of daily living except required total assistance of one staff person for bathing and was coded for supervision and set up only for eating; She was also coded as frequently incontinent of bowel and bladder. On 2/6/2018 at 9:30 AM, review of the clinical record was conducted. Review of the clinical record revealed a hard copy	F 755	Scheduled II, III, and IV Controlled Substances was reviewed and remains current. -Education provided to license nursing staff on the established Medication Policy and procedures for New Orders for Scheduled II, III, and IV Controlled Substances. 2. Identification of other residents who have the potential to be affected: - All Resident charts were audited for hard copy narcotic prescriptions any hard copy narcotic prescriptions were returned to the pharmacy. Completed 02/07/2018 3. Additional measures shall be put in place to ensure this identified practice will not recur: - Licensed Nurses after faxing Schedule II, III, or IV Controlled Substance prescription to the pharmacy will deface the hard copy controlled substance prescription and per policy and place, the defaced prescription into the Prescription Return Bag located in the Nursing Supervisor office. - Supervisors will log each prescription returned to pharmacy in the Controlled Substance Prescription Return log. - In-service by the Consultant Pharmacist/designee shall be provided to and required of current licensed Nursing staff on the Medication Policy and procedures for New Orders for Scheduled II, III and IV Controlled Substances to include Delivery and Receipt of Routine/Emergency/STAT Deliveries -Education and training on Medication	

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F 755	Continued From page 36 of a written prescription for a narcotic dated 12/302017 from the hospital.. There was a hard script dated 12/30/2017 for Oxycodone (Roxicodone) 5 milligrams immediate release tablet, take 0.5 (2.5 milligrams) total by mouth every 4 hours as needed for pain. Route: Oral. Quantity 70 (Seventy) tablets. There was no line drawn through the prescription to indicate the prescription had been filled. Review of the Physicians Orders Summary for 2/7/ 2018 revealed an order written on 1/27/2018 Oxycodone 5 milligrams tablet, take 0.5 total by mouth every 4 hours as needed for pain. Route: Oral. On 2/7/2018 at 2:45 PM, an interview was conducted with the RN (Registered Nurse) Supervisor (RN A) who stated prescriptions for narcotics should be faxed to the Pharmacy. RN A stated a copy of the prescription should be left inside the chart, with a line drawn through the prescription. On 2/7/2018 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated after faxing a copy, the hard scripts should be sent to the Pharmacy and a copy should be left in the chart. On 2/7/2018 at 3:30 PM, an interview was conducted via the telephone with the Consultant Pharmacist who stated the facility had a procedure in place to handle prescriptions for narcotic. The Consultant Pharmacist (Admin F) stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record and the actual prescription should be sent to the	F 755	policy and procedures for New Orders for Scheduled II, III, and IV Controlled Substances to include Delivery and Receipt of Routine/Emergency/STAT Deliveries shall be included in orientation for newly hired Licensed Nursing staff. 4. Monitoring mechanisms to assure compliance: Supervisor/ designee will conduct weekly audits of physician orders for Controlled Substance orders cross checking with Controlled Substance Return log to ensure hard copy prescriptions have been sent to the pharmacy for three months. The audits shall be provided to the Director of Nursing /designee for review and results turned in to QAA committee for review and appropriate action 5. All actions will be completed by 3-8-2018	

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Pharmacy. There was a poor telephone connection and the Pharmacist stated she was at another facility at that moment but would call the surveyor the next morning at 9 AM from a different telephone to clarify.

During the end of day debriefing on 2/7/2018 at 4:15 PM, the facility Administrator, Assistant Director of Nursing (Admin B) and the corporate representative were informed of the findings. Admin B stated the professional guidance was provided by Lippincott.

On 2/8/2018 at 8:55 AM, the Pharmacy Consultant (Admin F) came to the conference room to talk with the surveyor. Admin F apologized about the telephone connection on the previous day but stated she decided to come to the facility to clarify any concerns. Admin F stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record, a line should be drawn through the copy of the prescription and the actual prescription should be sent to the Pharmacy. Admin F stated the Pharmacy delivers to the facility twice a day. Admin F stated her supervisor, the Pharmacist in Charge, wanted to talk with the surveyor about the procedures regarding narcotics. Admin F reviewed the Resident # 397's clinical record and saw the hard script for Oxycodone. Admin F stated the prescription should have been sent to the Pharmacy by facility staff. Admin F agreed that the prescription was not secure as filed in the clinical record.

On 2/8/2018 at 9:06 AM, a telephone interview was conducted with the Pharmacist in charge (Admin G) stated the facility was "supposed to

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forward the hard copies of narcotics to the Pharmacy in a bag and that the Pharmacy delivery person comes twice a day" to the facility.

During the end of day debriefing on 2/8/2018, the facility Administrator, Assistant Director of Nursing and Corporate Manager were informed of the failure of the staff to ensure the implementation of a method of safekeeping of hard scripts for narcotics. The nursing staff did not forward the hard copy of the narcotic prescription to the Pharmacy and the Pharmacy did not make sure it received the hard copy of the narcotic prescription. There was the potential of diversion of controlled drugs.

No further information was provided.

2. For Resident # 19, the facility staff failed to send a hard copy script dated 1/16/2017 for Oxycodone 5 milligrams to the Pharmacy.

Resident # 19 was a 88 year old male admitted to the facility on 1/16/2017 with the diagnoses of, but not limited to, Hypertension, Diabetes, Peripheral Vascular Disease, Dyspnea, Anxiety, Pain and Coronary Artery Disease.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/27/17. The MDS coded Resident # 19 with a BIMS (Brief Interview for Mental Status) of 11/15 indicating moderate cognitive impairment; Resident # 19 required extensive assistance of one staff person to two staff persons with activities of daily living except

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required supervision and set up only for eating; He was also coded as having an Ostomy and frequently incontinent of bowel and bladder.

On 2/6/2018 at 9:30 AM, review of the clinical record was conducted.

Review of the clinical record revealed a hard copy of a written prescription dated 1/16/17 for Oxycodone 5 milligrams one tablet oral every 4 hours as need for pain Dispense/supply 30 tablets with no refills.

Review of the signed Physicians Order Summary dated 1/10/2018 revealed no current order for Oxycodone.

On 2/7/2018 at 2:45 PM, an interview was conducted with the RN (Registered Nurse) Supervisor (RN A) who stated prescriptions for narcotics should be faxed to the Pharmacy. RN A stated a copy of the prescription should be left inside the chart, with a line drawn through the prescription.

On 2/7/2018 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated after faxing a copy, the hard scripts should be sent to the Pharmacy and a copy should be left in the chart.

On 2/7/2018 at 3:30 PM, an interview was conducted via the telephone with the Consultant Pharmacist who stated the facility had a procedure in place to handle prescriptions for narcotic. The Consultant Pharmacist (Admin F) stated the nursing staff should fax the order for narcotics, a copy of the prescription should be

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kept at the facility in the clinical record and the actual prescription should be sent to the Pharmacy. There was a poor telephone connection and the Pharmacist stated she was at another facility at that moment but would call the surveyor the next morning at 9 AM from a different telephone to clarify.

During the end of day debriefing on 2/7/2018 at 4:15 PM, the facility Administrator, Assistant Director of Nursing (Admin B) and the corporate representative were informed of the findings. Admin B stated the professional guidance was provided by Lippincott.

On 2/8/2018 at 8:55 AM, the Pharmacy Consultant (Admin F) came to the conference room to talk with the surveyor. Admin F apologized about the telephone connection on the previous day but stated she decided to come to the facility to clarify any concerns. Admin F stated the nursing staff should fax the order for narcotics, a copy of the prescription should be kept at the facility in the clinical record, a line should be drawn through the copy of the prescription and the actual prescription should be sent to the Pharmacy. Admin F stated the Pharmacy delivers to the facility twice a day. Admin F stated her supervisor, the Pharmacist in Charge, wanted to talk with the surveyor about the procedures regarding narcotics. Admin F reviewed the Resident # 19's clinical record and saw the hard script for Oxycodone. Admin F stated the prescription should have been sent to the Pharmacy by facility staff. Admin F agreed that the prescription was not secure as filed in the clinical record.

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On 2/8/2018 at 9:06 AM, a telephone interview was conducted with the Pharmacist in charge (Admin G) stated the facility was "supposed to forward the hard copies of narcotics to the Pharmacy in a bag and that the Pharmacy delivery person comes twice a day" to the facility.

Per the surveyor's request, Admin B provided a copy of the pharmacy delivery summary.
Review of the Pharmacy Proof of Delivery Shipment Summary revealed Oxycodone 5 milligrams tablets quantity 30 was filled on 1/16/2017.
Admin B stated the nursing staff should have faxed a copy of the prescription, made a copy for the chart with a line drawn through it and forward the hard copy to the Pharmacy in the bag.

During the end of day debriefing on 2/8/2018, the facility Administrator, Assistant Director of Nursing and Corporate Manager were informed of the failure of the staff to ensure the implementation of a method of safekeeping of hard scripts for narcotics. The nursing staff did not forward the hard copy of the narcotic prescription to the Pharmacy and the Pharmacy did not make sure it received the hard copy of the narcotic prescription. There was the potential of diversion of controlled drugs. There was the potential of diversion of controlled drugs.

No further information was provided.

3. Resident # 398 was a 75 year old female admitted to the facility on 5/11/2017 with the diagnoses of, but not limited to, Fracture of Neck

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of Left Femur, History of Falling, Chronic Obstructive Pulmonary Disease, Dementia, Hypothyroidism and Hyperlipidemia.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 1/7/2018. The MDS coded Resident # 398 with a BIMS (Brief Interview for Mental Status) of 10/15 indicating moderate cognitive impairment; Resident # 398 required extensive assistance of one staff person to two staff persons with activities of daily living except required supervision and set up only for eating; She was also coded as frequently incontinent of bowel and bladder. Resident # 398 was coded as requiring oxygen therapy.

On 2/6/2018 at 9:30 AM, review of the clinical record was conducted.

On the inside of the clinical record were plastic sleeves covering several sheets of papers. Under one plastic sleeve that included a document about Code Status, there were several hand written prescriptions. One of the prescriptions was a hard copy of a written prescription for a narcotic dated 5/24/17 for Norco 5/325 one tablet by mouth every 4 hours as needed Quantity 100. There were no marks on the prescription indicating the disposition of whether the prescription had been filled or was no longer valid.

There was no indication the prescription had ever been filled.

On 2/7/2018 at 2:45 PM, an interview was conducted with the RN (Registered Nurse)

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Supervisor (RN A) who stated prescriptions for narcotics should be faxed to the Pharmacy. RN A stated a copy of the prescription should be left inside the chart, with a line drawn through the prescription.

On 2/7/2018 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated after faxing a copy, the hard scripts should be sent to the Pharmacy and a copy should be left in the chart.

After reviewing the record, the Assistant Director of Nursing (Admin B) stated Resident # 398 was supposed to be discharged to home in May 2017 and the prescriptions were supposed to be given to her at discharge. Admin B stated the staff should have forwarded the prescription for the narcotic to the pharmacy or marked as voided if it was not to be filled. Admin B agreed that the prescription was not secure in the clinical record.

On 2/8/2018 at 8:55 AM, the Pharmacy Consultant (Admin F) came to the conference room to talk with the surveyors. Admin F stated her supervisor, the Pharmacist in Charge, wanted to talk with the surveyor about the procedures regarding narcotics. Admin F reviewed the Resident # 398's clinical record and saw the hard script for Norco. Admin F stated the prescription should have been sent to the Pharmacy by facility staff.
Admin F agreed that the prescription was not secure as filed in the clinical record.

On 2/8/2018 at 9:06 AM, a telephone interview was conducted with the Pharmacist in charge (Admin G) stated the facility was "supposed to

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F 755	Continued From page 44 forward the hard copies of narcotics to the Pharmacy in a bag and that the Pharmacy delivery person comes twice a day" to the facility. During the end of day debriefing on 2/8/2018, the facility Administrator, Assistant Director of Nursing and Corporate Manager were informed of the failure of the staff to ensure the implementation of a method of safekeeping of hard scripts for narcotics. The nursing staff did not forward the hard copy of the narcotic prescription to the Pharmacy and the Pharmacy did not make sure it received the hard copy of the narcotic prescription. There was the potential of diversion of controlled drugs. There was the potential of diversion of controlled drugs. No further information was provided.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/8/18

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F 761	Continued From page 45 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on Observation, Staff Interview, and Clinical Record Review, facility staff failed to ensure expired medication was not available for use, for one resident (Resident #21) out of 19 residents in the survey sample. Facility staff failed to dispose of expired Novolog Insulin and left it labeled for use in Medication Cart #3. The Findings included: On 02/07/18 at 10:00am an inspection of the facility Medication Carts was conducted. In Medication Cart #3, a vial of Novolog insulin prescribed for Resident #21 was found with a date of 10/22/17 written on the bottle. RN (Registered Nurse) C, who was assigned Medication Cart #3, was asked what the dates on the medications represented. RN C stated that the date written on the bottle was the date the medication was opened. RN C was asked how long opened insulin was to be used. RN C stated "28 days". RN C was asked about the date on the vial of insulin and responded "Its old". Resident #21, a 94 year old, was admitted to the facility on 05/04/16. Diagnoses included	F 761	F761 Label/Store Drugs and Biologicals □ Insulin 1. Actions taken for the (1) resident identified: - The Identified Novolog Insulin vial for Resident #21 was observed in Medication Cart #3 on 02/07/2018. . The identified medication was immediately removed from use and discarded on 02/07/2018. There were no other expired medications found 2. Identification of other residents who have the potential to be affected: -On 02/07/2018 each medication cart and the medication refrigerator was audited by administrative nursing staff and assigned nursing staff to ensure that no other medications were expired eliminating the potential for other residents to be affected by the same identified practice. No other expired medications were found. 3. Additional measures shall be put in place to ensure this identified practice will not recur: -In-service training by the Consultant	

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F 761	Continued From page 46 congestive heart failure, diabetes type 2, high blood pressure, and depression. Resident #21's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/3/18 was coded as a significant change in status assessment. The resident was coded as having a BIMS (brief interview of mental status) of "9" out of a possible 15, or moderate cognitive impairment. Resident #21 was also coded as requiring extensive assistance of one staff member to perform activities of daily living (ADL's), but requires supervision of one staff member for eating. Resident #21 had a physician order for Novolog dated 07/30/17. Review of Resident #21's MAR revealed they had most recently received a dose of 4 units of Novolog Insulin on 01/05/18. The Facility Administrator and ADON were made aware of the finding at the End-of-Day meeting on 02/07/18.	F 761	Pharmacist/designee shall be provided to and required of licensed Nursing staff on the Medication Policy and procedures for administration, storage, handling, and discarding of medication. -Education and training on Medication policy and procedures for administration, storage handling, and discarding of medication shall be included in orientation for all newly hired licensed nursing staff. -Implementation of a weekly checklist for Medication cart and Medication refrigerator cleaning and auditing for expired medications. 4. Monitoring mechanisms to assure compliance: Monthly audits of medication carts and medication refrigerators will be conducted by RN Nursing Supervisory staff/designee alternating with Pharmacy staff for three months. 5. The audits shall be provided to the Director of Nursing /designee for review and results turned in to QAA committee for review and appropriate action. All actions will be completed by 3-8-2018	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		3/8/18

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F 835	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility Administrator failed to ensure the facility was administered in a manner to ensure the safety of residents with hot liquids. Resident #21 received second degree burns on her abdomen from spilling hot coffee on 1/28/18. Following the event, the Administrator did not ensure temperatures of hot liquids were monitored and assessments for safety with hot liquids were not conducted; residents had access to a hot coffee machine dispensing hot liquids at 177 degrees Fahrenheit. The findings included: The Administrator stated that after Resident #21 was burned on 1/28/18, the dietary staff began to monitor the temperatures of the hot beverages served. The Administrator was asked to provide the coffee temperature logs. Another surveyor and the Administrator entered the main kitchen on 2/6/18 at 7:05 p.m. to review the hot beverage temperature logs. The Administrator asked the Kitchen Manager (Employee B) for the logs. She stated that the log for the dinner meal that evening had not been returned from the floor yet. She was asked to provide the log and all of the logs since 1/28/18. Employee B stated that the dietary department did not have temperature logs from 1/28/18 because they just started taking the temperatures of hot liquids on 2/5/18 after the survey team asked about hot liquid temperatures during the initial tour of the kitchen. She was asked to provide the temperature log for the dinner meal on 2/6/18 once it was located. As of	F 835	F835 Administration It is the intent of this facility for all residents to remain free of injury from hot liquids. 1. Actions taken: -Coffee Machine was immediately removed from the South dining hall- Completed 2-6-18 - A Hot Liquids Risk Assessment was completed for Identified Resident #21. Recommendation by IDT was made for Resident to use a coffee cup with a secure lid to minimize recurrence and promote resident safety. Resident agreed to use coffee cup with a secure lid for safety. Care plan was revised to include recommendation of coffee cup with a secure lid for safety. Completed 02/06/18 2. Other residents having the potential to be affected by this alleged deficient practice: An initial Hot Liquids Risk Assessment was completed for all residents to identify anyone who would be at risk for spillage and/or injury from coffee/hot liquids. Any identified to be at risk were referred to the Interdisciplinary team (IDT) for recommendations to minimize their risk for injury and promote resident safety. Completed 02/07/18 3. Measures put into place/ systemic: -Facility Staff in-serviced in regards to resident safety with hot liquids and Policy and Procedure for Hot Liquids Risk	

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F 835	Continued From page 48 the conclusion of the survey on 2/8/18, the temperature log for the 2/6/18 dinner meal was not provided. During tour on 2/5/18 at 2:48 PM, food /temperature logs were reviewed. No hot beverage temperatures were taken. Kitchen manager stated that it was the "nursing staff's responsibility to take the coffee temperatures." He said that there were currently no residents who were using special cups with two handles. He further stated that no residents had ever been burned. 2/6/18: 6:20 PM: The facility Administrator and acting DON were notified of needed information. The Administrator stated the facility had a mock survey completed and had identified there was no policy for hot liquids and had also reviewed this on their QA (quality assurance meeting) monthly meeting on 1/26/18..(prior to Resident #21's burn). On 2/6/18 at 6:45 p.m. the Administrator and Director of Therapy (Employee F) were interviewed regarding the plan put into place after Resident #21 was burned by the hot coffee. The Administrator stated that all residents were screened by therapy. The Director of Therapy stated that the residents were screened for the need of adaptive equipment during self feeding. She stated that all residents were screened to use a cup without a lid. When asked if the screening she completed was a hot liquid assessment, the Director of Therapy stated no. When asked if her screen was to assess the physical ability versus the cognitive ability of the residents to drink hot liquids, the Director of	F 835	Assessment by Nurse Educator/designee by 02/07/18. Action initiated and is ongoing. - All residents will be assessed for risk of use of hot liquids by licensed nurse or therapist to minimize their risk for injury and promote resident safety with all new admissions, quarterly, significant change and re-assessed if the resident experiences injury from spilled hot liquids. Coffee carafes- 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur: Dining Services /designee will conduct daily audits of hot liquid temperature prior to leaving kitchen. Audits will be conducted for three months and results turned in to QAA committee for review and appropriate action. 5. All actions will be completed by 3-8-2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495280	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 49 Therapy stated that her assessment was of physical ability only. They were dated 1/10/18 to 1/11/18, prior to Resident #21's burn. On 2/8/18, prior to the end of the day meeting, the Administrator and Executive Director were notified of above findings.	F 835		