STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495301	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL FRONT ROYAL	400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630

(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 08/21/18 through 08/23/18. The facility was found to be in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. An unannounced Emergency Preparedness survey was conducted 08/22/18 through 08/23/18. This facility is in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550	**F550** **Corrective Action(s):** C.N.A. #1 involved in feeding residents #3 & #24 has been inserviced on resident Rights and Dignity regarding sitting and not standing while feeding residents and using a napkin to clean food off residents faces and not a spoon. A facility Incident & Accident form has been completed for this incident. An Incident & Accident form was completed for the incident involving resident #35 who had their meal tray sat down in front of them and did not receive feeding assistance after her tray was set up in front her. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have the potentially been affected. The Administrator and DON will assess the dining experience and process for meal delivery in the dining room to establish a formal tray set up, delivery and feeding assistance process to ensure all staff are providing a dignified dining experience and providing assistance with their meal trays in a timely manner.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natasha Tyson LNHA — TITLE: administrator — (X6) DATE: 9/20/18

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 a dignified dining experience for three of 31 residents in the survey sample, Residents #3, #24 and 335. 1. The facility staff failed to provide dignity for Resident #3 during lunch on 8/21/18. CNA (Certified nursing assistant) #1 stood while feeding the resident a portion of lunch. 2. The facility staff failed to provide dignity for Resident #24 during lunch on 8/21/18. CNA #1 stood while feeding the resident a portion of lunch and food from the resident's lips with a spoon. 3. The facility staff failed to feed Resident #35 immediately after placing a meal tray in front of the resident. On 8/21/18, a CNA placed a meal tray on the table in front of Resident #35 and the resident was not fed for eight minutes.	F 550	**Systemic Change(s):** Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services will inservice all staff on the facility policy and procedure regarding resident rights and dignity. The inservice will also cover the procedure for proper meal tray delivery and assistance to ensure all residents are served in a timely manner and receive meal assistance at the same table. **Monitoring:** The DON and Administrator are responsible for compliance. The DON or Administrator and/or designee will complete the 3 meal pass audit weekly to monitor for compliance. All negative findings will be corrected at the time of discovery. The audit findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: 10/1/18**	

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F 550	Continued From page 2	F 550		

The findings include:

1. The facility staff failed to provide dignity for Resident #3 during lunch on 8/21/18. CNA (Certified nursing assistant) #1 stood while feeding the resident a portion of lunch.

Resident #3 was admitted to the facility on 2/18/05. Resident #3's diagnoses included but were not limited to severe intellectual disabilities, legal blindness and difficulty swallowing. Resident #3's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/7/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #3 as requiring extensive assistance of one staff with eating.

On 8/21/18 at 12:20 p.m., CNA #1 was observed feeding Resident #3 and another resident sitting across the table in the restorative dining room. CNA #1 stood while alternating bites of food to each resident until another CNA came in to feed Resident #3.

On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked what should be done to provide a dignified dining experience. LPN #5 stated, "We want to make sure we tell them what there is to eat. Give them as many choices as we can. Offer everything. We don't want to do too big of a bite so that creates less of a mess. Conversation." When asked where staff should be positioned in relation to a resident he or she is feeding, LPN #5 stated, "Sitting next to them."

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F 550	Continued From page 3 On 8/22/18 at 2:12 p.m., an interview was conducted with CNA #1. CNA #1 was asked what should be done to provide a dignified dining experience. CNA #1 stated, "That's why we have restorative dining; anybody that needs to be helped they come over and help us." When asked where she should be positioned when feeding a resident, CNA #1 stated, "If somebody is right there, I sit beside them." Resident #3's comprehensive care plan dated 8/6/18 failed to document information regarding the above concern. On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings. The facility policy titled, "Assistance with Meals" documented, "3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity for example: a. Not standing over residents while assisting them with meals..." No further information was presented prior to exit. 2. The facility staff failed to provide dignity for Resident #24 during lunch on 8/21/18. CNA #1 stood while feeding the resident a portion of lunch and food from the resident's lips with a spoon. Resident #24 was admitted to the facility on 3/24/11. Resident #24's diagnoses included but were not limited to difficulty swallowing, abnormal posture and high blood pressure. Resident #24's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference	F 550		

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F 550	Continued From page 4	F 550		

date) of 6/29/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #24 as requiring extensive assistance of one staff with eating.

On 8/21/18 at 12:20 p.m., CNA #1 was observed feeding Resident #24 and another resident sitting across the table in the restorative dining room. CNA #1 stood while alternating bites of food to each resident until another CNA came in to feed the other resident. On multiple occasions, CNA #1 was observed scraping excess food from Resident #24's lips with the spoon.

On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked what should be done to provide a dignified dining experience. LPN #5 stated, "We want to make sure we tell them what there is to eat. Give them as many choices as we can. Offer everything. We don't want to do too big of a bite so that creates less of a mess. Conversation." When asked where staff should be positioned in relation to a resident he or she is feeding, LPN #5 stated, "Sitting next to them." LPN #5 was asked how food should be removed from a resident's face. LPN #5 stated, "Use a napkin. If they needed help I would do it." LPN #5 was asked how she would feel if food was removed from her face with a spoon. LPN #5 stated, "I guess like an infant."

On 8/22/18 at 2:12 p.m., an interview was conducted with CNA #1. CNA #1 was asked what should be done to provide a dignified dining experience. CNA #1 stated, "That's why we have restorative dining; anybody that needs to be helped they come over and help us." When

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F 550	Continued From page 5 asked where she should be positioned when feeding a resident, CNA #1 stated, "If somebody is right there, I sit beside them and wipe their mouth when stuff is all over it." When asked how she wipes the resident's mouth, CNA #1 stated, "I use their protective cover (a clothes cover)." When asked if she could use a napkin, CNA #1 stated, "We can use napkins." When made aware of this surveyor's observation, CNA #1 stated, "I was wiping her face." Resident #24's comprehensive care plan dated 6/28/18 failed to document information regarding the above concern. On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings. No further information was presented prior to exit. 3. The facility staff failed to feed Resident #35 immediately after placing a meal tray in front of the resident. On 8/21/18, a CNA placed a meal tray on the table in front of Resident #35 and the resident was not fed for eight minutes. Resident #35 was admitted to the facility on 12/18/15. Resident #35's diagnoses included but were not limited to dementia, right eye blindness and difficulty swallowing. Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/18, coded the resident's cognition as severely impaired. Section G coded Resident #35 as requiring extensive assistance of one staff	F 550		

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F 550	Continued From page 6	F 550		

with eating.

On 8/21/18 at 12:18 p.m., a CNA placed a covered meal tray in front of Resident #35. The resident was not offered assistance with the meal for eight minutes.

On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked how long it should take to offer assistance to a resident after a meal tray has been placed in front of him or her. LPN #5 stated, "If there is food sitting in front of them they shouldn't be waiting too long." When asked to describe "too long," LPN #5 stated, "I would say they shouldn't be waiting more than five minutes. There may be a case where you put the tray down and someone needs a straw so you get that then return; other than that you should be feeding them." When asked how she would feel if she required assistance with eating and a meal was placed in front of her for eight minutes before receiving assistance, LPN #5 stated, "Hungry."

On 8/22/18 at 2:12 p.m., an interview was conducted with CNA #1. CNA #1 was asked how long it should take to offer assistance to a resident after a meal tray has been placed in front of him or her. CNA #1 stated, "When we place it there."

Resident #35's comprehensive care plan dated 7/12/18 failed to document information regarding the above concern.

On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above

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F 550	Continued From page 7 findings. No further information was presented prior to exit.	F 550		10/1/18
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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- §483.10(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 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. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	**F584** **Corrective Action(s):** C.N.A. #1 involved in the meal pass delivery in the restorative dining room that delivered residents #3, #24 & #35's meal tray has been inserviced on providing a homelike dining experience to all residents which includes removing the meal plates, utensils and drinks from the serving tray. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have the potentially been affected. The Administrator and DON will assess the dining experience and process for meal delivery in the dining rooms and resident rooms to establish a formal tray set up, delivery and feeding assistance process to ensure all staff are providing a dignified homelike dining experience. **Systemic Change(s):** Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services will inservice nursing and dietary staff on the facility policy and procedure for providing a homelike dining experience during all meals. The inservice will cover removing all meal plates, utensils and drinks from the serving tray when delivery resident meals to ensure all residents are receiving a homelike dining experience.	

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F 584	Continued From page 8 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. 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 a homelike dining experience for three of 31 residents in the survey sample, Residents #3, #24, #35. The facility staff failed to provide a homelike dining experience for Residents #3, #24 and #35 during lunch on 8/21/18. The residents were served meal plates on serving trays. The findings include: Resident #3 was admitted to the facility on 2/18/05. Resident #3's diagnoses included but were not limited to severe intellectual disabilities, legal blindness and difficulty swallowing. Resident #3's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/7/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #3 as requiring extensive assistance of one staff with eating. Resident #24 was admitted to the facility on 3/24/11. Resident #24's diagnoses included but were not limited to difficulty swallowing, abnormal posture and high blood pressure. Resident #24's	F 584	**Monitoring:** The DON and Administrator are responsible for compliance. The DON, unit managers and/or designee will complete the 3 meal pass audit weekly to monitor for compliance. All negative findings will be corrected at the time of discovery. The audit findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: 10/1/18**	

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F 584	Continued From page 9	F 584		

most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/29/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #24 as requiring extensive assistance of one staff with eating.

Resident #35 was admitted to the facility on 12/18/15. Resident #35's diagnoses included but were not limited to dementia, right eye blindness and difficulty swallowing. Resident #35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/18, coded the resident's cognition as severely impaired. Section G coded Resident #35 as requiring extensive assistance of one staff with eating.

On 8/21/18 at 12:13 p.m., a dining observation was conducted in the restorative dining room. The staff served Residents #3, #24 and #35 their meal plates on serving trays and did not remove the trays while assisting the residents with their meals. Some other residents' meal plates were observed removed from the serving trays.

On 8/22/18 at 2:12 p.m., an interview was conducted with CNA (certified nursing assistant) #1 (a CNA who served lunch in the restorative dining room on 8/21/18). CNA #1 was asked why some residents were served meals on trays and others were not. CNA #1 stated, "They were supposed to come off the trays. We might have been a little nervous because you guys are here...The ones we feed, they don't touch their food." When asked if there was any reason Residents #3, #24 and #35's meals were left on trays, CNA #1 stated, "No. We took them off

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F 584	Continued From page 10 didn't we?" When asked why staff is supposed to remove meals from serving trays, CNA #1 stated, "It's nice dining; more like being at home." On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings. The facility document titled, "Quality of Life-Homelike Environment" documented, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible." No further information was presented prior to exit.	F 584		10/1/18
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623	**F623** **Corrective Action(s):** Resident #96's resident representative has been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 8/10/18. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding.	

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F 623	Continued From page 11 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State	F 623	**Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing administration on the requirement that a resident's responsible party and the state ombudsman be notified of resident discharges/transfers. **Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:10/1/18**	10/1/18

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F 623	Continued From page 12 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff	F 623		

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F 623	Continued From page 13 failed to provide written notification to the RR (resident representative) for a facility-initiated transfer for one of 31 residents in the survey sample, Resident #96. Resident #96 transferred to the hospital on 8/10/18. The facility staff failed to provide written notification of the facility-initiated transfer to the resident's representative. The findings include: Resident #96 was admitted to the facility on 12/20/16. Resident #96's diagnoses included but were not limited to convulsions, diabetes and urinary tract infection. Resident #96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/18, coded the resident as being cognitively intact. Review of Resident #96's clinical record revealed the resident was transferred to the hospital on 8/10/18 due to a fever and abnormal vital signs. Further review of Resident #96's clinical record failed to reveal written notification of the transfer was provided to the resident's representative. On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (one of the nurses who assisted with Resident #96's hospital transfer). LPN #5 stated she calls a resident's representative when a resident is transferred to the hospital. When asked if she provides written notice to the representative, LPN #5 stated, "Typically they don't come in to us; they go to the hospital. If they come in to get their belongings." When again asked if she provides written notice, LPN #5 stated, "I don't do that."	F 623		

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F 623	Continued From page 14 On 8/22/18 at 2:29 p.m., LPN #5 presented other requested documentation regarding Resident #96's hospital transfer and a blank consent for inter-facility or intra-facility transfer form. The consent for inter-facility or intra-facility transfer form documented, "Resident: _____. Date: _____. Time: _____. I have been fully informed of my rights regarding transfers. I understand that I am being transferred from (name of facility) to (blank space to be filled out). I understand the reason for transfer to be (blank space to be filled out)..." The form designated a signature line for the resident and/or RR. On 8/22/18 at 4:56 p.m., another interview was conducted with LPN #5. LPN #5 stated she called but could not reach Resident #96's representative when the resident was transferred to the hospital on 8/10/18. LPN #5 stated that later that day, the representative came to the facility to see the resident so she informed the representative that Resident #96 had been transferred to the hospital. LPN #5 stated Resident #96's representative went to the hospital to see the resident and then came back to the facility and gave staff an update on the resident's condition. When asked if she ever attempted to give Resident #96's representative the consent for the inter-facility or intra-facility form, LPN #5 stated she did not. When asked if she filled out the form and sent the form with Resident #96 to the hospital, LPN #5 stated she did not. On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings.	F 623		

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F 623	Continued From page 15 The facility document titled, "Discharging the Resident" failed to document information regarding the above concern. No further information was presented prior to exit.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656	**F656** **Corrective Action(s):** Resident #6's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific Oxygen usage and treatment needs. A Facility Incident & Accident Form was completed for this incident. Resident #96's comprehensive care plan and C.N.A. has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include the use of appropriate personal protective equipment when entering a resident room who is on Isolation. A Facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans and C.N.A. care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive and C.N.A. care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 656	Continued From page 16 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for two of 31 residents in the survey sample, Residents #6, #11, and #96. 1. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #6. 3. The facility staff failed to implement Resident #96's comprehensive care plan for contact precautions. The findings include: 1. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #6. Resident #6 was admitted to the facility 4/20/16 with diagnoses, which included but were not limited to: anxiety disorder, arthritis, depression, diabetes, high blood pressure, and dementia.	F 656	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:10/1/18**	

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The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/28/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as having used oxygen within the last 14 days of the look back period.

The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: At risk for SOB (shortness of breath) due to DX (diagnosis) of COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1)." The "Approaches" documented in part, "O2 [oxygen] as ordered."

Observation was made of Resident #6 on 8/22/18 at 8:06 a.m. The resident was in bed with her oxygen on via the nasal cannula (plastic tube with two prongs that insert into the nose) connected to an oxygen concentrator. The oxygen concentrator was set at 4L/min (liters/minute).

A second observation was made of Resident #6 on 8/22/18 at 9:48 a.m. The resident was still in the bed with her oxygen on via the nasal cannula connected to an oxygen concentrator. The oxygen concentrator was set at 4L/min.

On 8/22/18 at 9:50 a.m., the oxygen concentrator was observed with LPN (licensed practical nurse) #3. LPN #3 verified that the oxygen flow meter was set at 4L/min. LPN #3 stated he did not have

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any residents prescribed for 4 liters. He stated she probably is supposed to be on 2 liters. LPN #3 went to the clinical record and verified the resident was to be on 2L/min per the physician order.

The physician order dated, 8/7/18, documented, "O2 (oxygen) @ (at) 2L/m (liters per minute) via nasal cannula at HS (hours of sleep - bedtime) per resident request. Remove O2 at 2L/min NC (nasal cannula) QAM (every morning)."

The August 2018 "Treatment Administration Record" (TAR) documented the above physician order. The TAR documented the administration of the oxygen every evening for each evening in August.

There was no documented nurse's notes for 8/22/18.

An interview was conducted with LPN #5 on 8/22/18 at 1:53 p.m. When asked the purpose of the care plan, LPN #5 stated, "It's to provide a plan of care to make sure all of their needs are met." When asked if it should be followed, LPN #5 stated, "Yes, it should be."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, and LPN #1, the assistant director of nursing, on 8/22/18 at 2:44 p.m. When asked the purpose of the care plan, ASM #2 stated, "It's to establish the goals of the resident and so that all the staff will be able to provide the care to reach their (the resident's) goals." When asked if the care plan should be followed, ASM #2 stated, "Yes, unless it is no longer appropriate. Then it should be updated."

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F 656	Continued From page 19 The facility policy, "Care Plans, Comprehensive Person-Centered" documented in part, "A comprehensive, person - centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident....2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment...8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, LPN (licensed practical nurse) #1, the assistant director of nursing, and ASM #5, the administrator in training, were made aware of the above concern on 8/22/18 at 6:00 p.m.	F 656		

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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 124.

2. The facility staff failed to implement Resident #96's comprehensive care plan for contact precautions.

Resident #96 was admitted to the facility on 12/20/16. Resident #96's diagnoses included but were not limited to convulsions, diabetes and urinary tract infection. Resident #96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/18, coded the resident as being cognitively intact.

Review of Resident #96's clinical record revealed a physician's order dated 8/15/18 for contact isolation due to ESBL (Extended-spectrum ß-lactamase (1)).

Resident #96's comprehensive care plan dated 6/11/18 documented, "CI (Contact isolation) (2) for MRSA (3) and ESBL in urine...Approaches: Contact isolation..."

Resident #96's CNA (certified nursing assistant) care plan failed to document information regarding contact isolation.

On 8/22/18 at 8:28 a.m., CNA #1 was observed in Resident #96's room, assisting the resident with a beverage. CNA #1 was not wearing a gown, mask or gloves. CNA #1 did not wash her hands

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F 656	Continued From page 21 before leaving the room. On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked the purpose of a care plan. LPN #5 stated, "To provide a plan of care to make sure we hit all areas of care for that patient to make sure their needs are being met." When asked how CNAs and nurses ensure they follow care plans, LPN #5 stated, "We have a mini care plan for the CNAs that's on the inside of the closet door. Each person has one that the CNA can follow and report (verbal shift to shift report)." LPN #5 was asked what she should do before entering and when leaving a contact isolation room. LPN #5 stated, "I'm going to use my protective gear which should be outside the room; put on whatever is suitable for the isolation. Knock on the door ask to enter the room. Before I leave, once I have done what I need to do, remove my stuff at the door to be able to wash my hands to leave the room." On 8/22/18 at 2:12 p.m., an interview was conducted with CNA #1. CNA #1 was asked what she should do before entering a contact isolation room. CNA #1 stated, "Gown up, mask and gloves." CNA #1 was asked what she should do before leaving a contact isolation room. CNA #1 stated, "Take it off, put it in the isolation carts in the room" When asked if she should wash her hands, CNA #1 stated, "Uh huh." On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings.	F 656		

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F 656	Continued From page 22 No further information was presented prior to exit. (1) "Extended-spectrum ß-lactamase is an enzyme that allows bacteria to become resistant to a wide variety of penicillin's and cephalosporins. Bacteria that contain this enzyme are known as ESBLs or ESBL-producing bacteria. ESBL-producing Enterobacteriaceae are resistant to strong antibiotics including extended spectrum cephalosporins." This information was obtained from the website: https://www.cdc.gov/drugresistance/biggest_threats.html (2) "Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf (3) "Methicillin-resistant Staphylococcus aureus (MRSA) causes a range of illnesses, from skin and wound infections to pneumonia and bloodstream infections that can cause sepsis and death. Staph bacteria, including MRSA, are one of the most common causes of healthcare-associated infections." This information was obtained from the website: https://www.cdc.gov/drugresistance/biggest_threats.html	F 656		10/1/18
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658	**F658** **Corrective Action(s):** Resident #11's attending physician has been notified that the facility staff failed to notify the attending physician of a blood sugar great than 400 per physician order and the facility staff failed to	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 23 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, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 31 residents in the survey sample, Resident #11. A. The facility staff failed to follow professional standards of practice for documenting notification of the physician for an elevated blood sugar for Resident #11. B. The facility staff failed follow professional standards of practice for the documenting the actual blood sugar readings for Resident #11. The findings include: A. Resident #11 was admitted to the facility on 7/21/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, anxiety disorder and mild cognitive impairment. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring no assistance to limited assistance for her activities of daily living. The physician order dated, 6/7/18, documented,	F 658	accurately document a blood sugar result on the Medication administration record. Resident #11's insulin orders and blood sugar monitoring orders have been reviewed to ensure all medication orders accurate. A Facility Incident & Accident Form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other diabetic residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all diabetic resident's medication orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physicians will be notified of each incorrect medication order. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include documenting blood sugars accurately and MD notification for blood sugars above 400 per physician order.	

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	495301	A. BUILDING _____ B. WING _____	C 08/23/2018

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F 658	Continued From page 24 "BS (blood sugar) AC (before) meals w/ (with) Novolog (a short acting insulin) (1) SQ (subcutaneous) Sliding Scale: Below 130 = O (units) 131 - 180 = 4 u (units) 181 - 240 = 8 u 241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 400 = 20 u & (and) call MD (medical doctor)." The June 2018 Medication Administration Record (MAR) documented the above medication order. On 6/26/18 at 4:30 p.m., the nurse documented the blood sugar as "436." RN (registered nurse) #2 documented this. Review of the MAR notes and the nurse's notes failed to evidence documentation of the physician being notified of the elevated blood sugar reading. The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: Diabetes Mellitus risk for high and lows of BS. Resident predicts her needs and intake based on how she thinks she is feeing vs (versus) actual number of glucose readings." The "Approaches" documented in part, "Give medications per orders. BS per order. Notify MD of changes in BS or s/s (signs and symptoms) of hypo/hyperglycemia (too low or too high blood sugars)." An interview was conducted with RN #2 on 8/22/18 at 6:46 p.m. RN #2 was asked to review the above order for sliding scale insulin. She was asked to review the MAR for 6/26/18. When asked if she notified the doctor of the blood sugar, RN #2 stated, "I know I did it. I wrote it in	F 658	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will conduct MAR and physician order reviews weekly for residents with insulin and blood sugar monitoring orders to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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her (the doctor's) communication book." RN #2 further stated, "I've been doing this for a long time. If it's not documented, I may have hit cancel or enter and it disappeared but I know I did it." RN #2 was asked to provide evidence that she documented the notification in the doctor's communication book.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 8/23/18 at 8:10 a.m. The blood sugar and nurse's notes were reviewed with ASM #2. When asked if they had found documentation of the notification in the doctor's communication book, ASM #2 stated they had not found it. ASM #2 further stated, "If it's not documented it's not done."

An interview was conducted with LPN (licensed practical nurse) #3 on 8/23/18 at 8:20 a.m. When asked if the sliding scale should be followed as written, LPN #3 stated, "Absolutely." When asked where physician notification documented if the blood sugar is greater than 400 and the doctor was notified as ordered, LPN #3 stated, "In the nurse's notes."

On 8/23/18 at 8:56 a.m., LPN #1 presented a document of blood sugars for Resident #11, which was printed on 6/27/18 at 6:32 a.m. The attending physician signed the paper. LPN #1 stated, "We print these out on the 11-7 (11:00 p.m. to 7:00 a.m.) shift for the doctors and nurse practitioners for the days they are coming to the facility." When asked if this document is part of the clinical record, LPN #1 stated, "No, Ma'am."

The facility policy, "Charting and Documentation" documented in part, "All services provided to the resident, progress toward the care plan goals, or

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F 658	Continued From page 26 any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...2. The following information is to be documented in the resident medical record: a. Objective observations. b. Medications administered. c. Treatments or services performed. d. Changes in the resident's condition. e. Events, incidents or accidents involving the resident. f. Progress toward or changes in the care plan goals and objectives." The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received ...Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m. When asked the standard of practice the facility uses, ASM #2 stated, "Lippincott." No further information was provided prior to exit. (1) This information was obtained from the following website:	F 658		

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd88e313-6193-4413-beff-7d955580060d

B. The facility staff failed follow professional standards of practice for the documenting the actual blood sugar readings for Resident #11.

The July 2018 MAR documented the order for the sliding scale insulin above. On 7/7/18, 7/8/18 and 7/22/18 at 4:30 p.m. there was no documented blood sugar reading. RN # 1 completed all three dates.

The July 2018 MAR notes documented the following on each of the above dates: "scheduled for 4:30 p.m. bs (blood sugar) < (less than) 130."

Review of the "Vital Signs" section of the electronic record failed to evidence documentation of the blood sugar readings on the above dates and times.

Review of the nurse's notes for the above dates failed to evidence documentation of the blood sugar readings.

An interview was conducted with RN #1 on 8/22/18 at 6:25 p.m. The above MAR was reviewed with RN #1. When asked how the blood sugar reading numbers are entered into the system, RN #1 stated, "A box pops up and you put in the reading." When asked if the actual number for the blood sugar reading should be included in the MAR, RN #1 stated, "I don't know why it isn't there."

An interview was conducted with LPN #3 on

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F 658	Continued From page 28 8/23/18 at 8:20 a.m. When asked where the blood sugar readings are documented, LPN #3 stated, "A box comes up and you put it there. It then populates to the blood sugar section in the vital signs." When asked if a nurse should document the blood sugar as less than 130, LPN #3 stated, "It's probably not in the best interest to do that." The facility policy, "Obtaining a Finger stick Glucose Level" documented in part, "Documentation...The person performing this procedure should record the following information in the resident's medical record:..6. The blood sugar results." The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 980) "Procedure: Measuring Blood Glucose by Skin Puncture...15. Share test results with client and record obtained values in the client chart." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m. When asked the standard of practice the facility uses, ASM #2 stated, "Lippincott." No further information was provided prior to exit.	F 658		9/1/18
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(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	F 659	**F659** **Corrective Action(s):** Resident #196's attending physician has been notified that facility staff failed to provide oxygen at the physician ordered flow rate and that facility staff failed to maintain the physician ordered usage schedule. A facility incident and accident form has been completed for this incident.	

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F 659	Continued From page 29 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, family interview, facility document review, and clinical record review it was determined the facility staff failed to administer Oxygen per the physicians order for one of 31 residents in the survey sample, Residents #196. The facility staff failed to ensure a trained staff member administered oxygen to resident #196 The findings include: Resident #196 was admitted to the facility on 8/13/2018 with diagnosis that included but were not limited to: chronic obstructive pulmonary disease (COPD- is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis). (1) There was no minimum data set (MDS) assessment completed at the time of the survey. The Nursing Admission Assessment dated 8/13/18 documented that the resident was alert and oriented. The physician order dated 8/13/2018 documented, "O2 (oxygen) at 2L/min (liters/minute) NC (nasal cannula - a plastic tube with two prongs that insert in the nose) continuous". On 08/21/18 at 03:45 p.m., Resident #196 was observed lying in bed wearing a NC connected to an oxygen concentrator with the oxygen flow rate	F 659	C.N.A. #1 received one on one inservice training on the C.N.A. job duties and the appropriate resident care to be provided by a C.N.A. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving physician ordered oxygen may have been potentially affected. The DON, ADON and/or Unit Managers will conduct a 100% review of all resident physician ordered oxygen orders to identify residents at risk for not following and/or implementing physician ordered oxygen orders. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for following and implementing physician ordered oxygen use has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all Nursing staff on following the physician ordered Oxygen orders to include correct flow rate and usage schedule. In addition, all C.N.A. staff will be inserviced on the appropriate job duties to be performed C.N.A. staff to include not adjusting or removing oxygen or tube feeding connections during resident care.	

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F 659	Continued From page 30 set to 2.5L/min. At this time, an interview with Resident #196 was conducted. Resident #196 stated they normally use "2.5" (liters of oxygen). On 08/22/18 at 08:04 a.m. a second observation was made; again the resident was lying in bed with oxygen set to 2.5L/min. The resident was asked if she adjusted her own oxygen, the resident denied doing this. On 08/22/18 2:16 p.m., a third observation was made. The resident was lying in bed with her daughter present at bedside without a NC being worn. The oxygen flow meter on the oxygen concentrator was turned on at a rate of 2-2.5L/min but was not being worn by the resident. At that time, the daughter who was with the resident was interviewed. Resident #196's daughter stated "staff had took off the oxygen to transfer her (Resident #196) back to bed thirty minutes prior but didn't put the oxygen back on". Review of the care plan dated 8/13/2018, failed to evidence documentation of the use of oxygen for Resident #196. An interview was conducted with Licensed Practical Nurse (LPN) #3 on 8/22/18 at 2:20 p.m. When asked what oxygen had been ordered for Resident #196, LPN #3 responded 2L/min. LPN #3 was then informed of the above observations of the resident receiving oxygen at 2.5 L/min. and informed Resident #196's NC was not being worn as ordered by the physician. LPN #3 was then asked to measure the resident's oxygen level using pulse oximetry. The result of this measurement was observed to be 80% (normal >90%). LPN #3 then placed O2 via NC on Resident #196 and the resident's oxygen level was then noted to be 93% via pulse oximetry. LPN #3 was then asked to read Resident #196's	F 659	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON, and/or Unit Manager will perform 3 random unit rounds weekly to monitor for appropriate oxygen use per physician orders to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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F 659	Continued From page 31 oxygen flow meter. LPN #3 read the flow meter and stated 2L. When asked how an oxygen flow meter was supposed to be read, LPN#3 responded, "The bottom of the ball is supposed to be at the top of the line." LPN 3# was then asked which staff had worked with Resident #196 earlier. LPN #3 replied certified nursing assistant (CNA) #1. When asked if CNA's can remove or adjust oxygen LPN#3 stated, "No". During an interview on 08/22/18 2:40 p.m. with CNA (Restorative Aid) #1, when asked if CNA's are allowed to administer oxygen, adjust oxygen or put and take oxygen on or off a resident, CNA#1 answered "yes". When CNA#1 was asked if she remove or adjust the oxygen for Resident # 196, CNA #1 answered "yes". On 8/22/18 at 2:44 p.m., an interview was conducted with administrative staff member (ASM) #2, the director of nursing (DON), and LPN # 1, the assistant director of nursing. Both were asked if the restorative aid was a CNA to which they both stated yes. When asked if a CNA can remove oxygen, turn it on or off, or adjust it in any way, ASM#2 answered, "That's the nurse's responsibility that would be a No." Review of the job description for a CNA did not evidence any documentation regarding the administration of oxygen. The Medication Administration Record for August 22, 2018 documented that oxygen was being administered to Resident #196 at 2L/min. According to the facilities oxygen administration policy prior to oxygen administration both the physicians order and care plan should be	F 659		

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F 659	Continued From page 32 reviewed. According to Fundamental of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." The administrator ASM #1 and ASM# 2 were made aware of the above concern 8/22/18 at 6:00 p. 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 124.	F 659		9/1/18
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 684	**F684** **Corrective Action(s):** Resident #11's attending physician was notified that the facility staff failed to follow the physician ordered sliding scale administer schedule. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving physician ordered sliding scale insulin orders may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all residents with physician ordered sliding scale insulin administration orders and MAR's to	

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F 684	Continued From page 33 and clinical record review, it was determined the facility staff failed to ensure treatment was provided in accordance with professional standards of practice, and the comprehensive care plan for one of 31 residents in the survey sample, Resident #11. The facility staff failed to follow the physician orders for sliding scale insulin administration for Resident #11. On 8/4/18 at 11:30 a.m., LPN (licensed practical nurse) #6 administered 16 units of Novolog insulin (a short acting insulin (1)) to Resident #11, instead of the physician prescribed 12 units of Novolog insulin for a blood sugar reading of 348. The findings include: Resident #11 was admitted to the facility on 7/21/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, anxiety disorder and mild cognitive impairment. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring no assistance to limited assistance for her activities of daily living. The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: Diabetes Mellitus risk for high and lows of BS. Resident predicts her needs and intake based on how she thinks she is feeing vs (versus) actual number of	F 684	identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. To include performing physician ordered sliding scale insulin administration orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and	

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F 684	Continued From page 34 glucose readings." The "Approaches" documented in part, "Give medications per orders. BS per order. Notify MD of changes in BS or s/s (signs and symptoms) of hypo/hyperglycemia (too low or too high blood sugars)." The physician order dated, 6/7/18, documented, "BS (blood sugar) AC (before) meals w/ (with) Novolog SQ (subcutaneous) Sliding Scale: Below 130 = O (units) 131 - 180 = 4 u (units) 181 - 240 = 8 u 241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 400 = 20 u & (and) call MD (medical doctor)." The August 2018 MAR (medication administration record) documented the above order. On 8/4/18 at 11:30 a.m., the nurse documented the blood sugar as "348." The documented amount of insulin administered was "16." The next recorded blood sugar on 8/4/18 at 4:30 p.m. documented the blood sugar as "74." An interview was conducted with LPN (licensed practical nurse) #3, on 8/23/18 at 8:22 a.m. When asked if physician orders for sliding scale insulin for blood sugars should be followed, LPN #3 stated, "Absolutely." An interview was conducted with LPN #6, the nurse that gave the insulin on 8/4/18 at 1:30 a.m., on 8/23/18 at 10:02 a.m. The above order for insulin was read to LPN #6. When asked what amount of insulin per the order, should the resident have received, for the blood sugar	F 684	recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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	495301	A. BUILDING _____ B. WING _____	C 08/23/2018

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F 684	Continued From page 35	F 684		

reading of 348, LPN #6 stated, "12 units." The MAR for August of 2018 was reviewed with LPN #6 and her documentation of administering "16" units. LPN #6 stated, "That was an error." When asked if that was following the physician's order, LPN #6 stated, "No, I made a mistake." The blood sugar on 8/4/18 at 4:30 p.m. was shared with LPN #6. LPN #6 stated, "I didn't realize I did that. That's a mistake and I am responsible."

The facility policy, "Administering Mediations," documented in part, "Medications shall be administered in a safe and timely manner, and as prescribed...7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication...20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered. b. The dosage. c. The route of administration. d. The injection site (if applicable)...g The signature and title of the person administering the drug."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m.

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F 684	Continued From page 36 (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd88e313-6193-4413-beff-7d955580060d	F 684		10/11/18
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 observations, resident interview, staff interview, family interview, facility document review, and clinical record review it was determined the facility staff failed to administer oxygen per the physicians order for two of 31 residents in the survey sample, Residents #196 and Resident #6. 1. The facility staff failed to administer oxygen, per the physician order, for Resident #196. 2. The facility staff failed to administer oxygen per the physician order, for Resident #6. The findings include: 1. Resident #196 was admitted to the facility on 8/13/2018 with diagnosis that included but were	F 695	**F 695** **Corrective Action(s):** Resident #196 & #6's attending physician was notified that residents #196 & #6 did not receive oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON, ADON and/or Unit Manager to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered. **Systemic Change(s):** The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order and the monitoring oxygen flow rates throughout the shift.	

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F 695	Continued From page 37 not limited to: chronic obstructive pulmonary disease (COPD- is a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis). (1) There was no minimum data set (MDS) assessment completed by the time of the survey. The Nursing Admission Assessment dated 8/13/18, documented the resident was alert and oriented. The physician order dated 8/13/2018 documented "O2 (oxygen) at 2L/min (liters/minute) NC (nasal cannula - a plastic tube with two prongs that insert in the nose) continuous". On 08/21/18 at 03:45 p.m., Resident #196 was observed lying in bed wearing a NC connected to an oxygen concentrator with the oxygen flow rate set to 2.5L/min. At this time, an interview with Resident #196 was conducted. Resident #196 stated they normally use "2.5" (liters of oxygen). On 08/22/18 at 08:04 a.m. a second observation was made; again the resident was lying in bed with oxygen set to 2.5L/min. The resident was asked if she adjusted her own oxygen, the resident denied doing this. On 08/22/18 2:16 p.m., a third observation was made. The resident was lying in bed with her daughter present at bedside without a NC being worn. The oxygen flow meter on the oxygen concentrator was turned on at a rate of 2-2.5L/min but was not being worn by the resident. At that time, the daughter who was with the resident was interviewed. Resident #196's daughter stated "staff had took off the oxygen to transfer her (Resident #196) back to bed thirty minutes prior but didn't put the oxygen back on".	F 695	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit manager will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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F 695	Continued From page 38	F 695		

Review of the care plan dated 8/13/2018, failed to evidence documentation of the use of oxygen for Resident #196.

An interview was conducted with Licensed Practical Nurse (LPN) #3 on 8/22/18 at 2:20 p.m. When asked what oxygen had been ordered for Resident #196, LPN #3 responded 2L/min. LPN #3 was then asked to read Resident #196's oxygen flow meter [Resident #196 was not observed wearing the nasal cannula at this time, but the oxygen concentrator was running]. LPN #3 read the flow meter and stated 2L. When asked how an oxygen flow meter was supposed to be read, LPN #3 responded, "The bottom of the ball is supposed to be at the top of the line". LPN #3 then placed O2 via NC on Resident #196. Observation of Resident #196 oxygen flow meter revealed the flow rate was set at 2.5 L/min. and not 2 L/mi. as ordered.

An interview was conducted with LPN #4 on 8/22/18 at 3:30 p.m. when asked how an oxygen flow meter is read LPN #4 responded, "The ball has to be mid-level to the line".

Interview on 8/22/18 at 2:44 p.m. with administrative staff member (ASM) #2, the director of nursing (DON), and LPN # 1, the assistant director of nursing. When asked how the oxygen flow meter should be read, LPN# 1 stated, "The line should be through the center of the ball."

According to the Resperonics EverFlo user manual page 6 for the oxygen concentrator that was at Resident #196's bedside, "Adjust the flow... until the ball is centered on the line

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F 695	Continued From page 39 marking the specific flow rate." The Medication Administration Record for August 2018, for Resident #196 documented that oxygen was being administered at 2L/min. According to the facilities oxygen administration policy "8. Place appropriate oxygen device on the resident ...10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. According to Fundamental of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." The administrator ASM #1 and ASM# 2, the director of nursing were made aware of the above concern 8/22/18 at 05:10 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 124. 2. The facility staff failed to administer oxygen per the physician order for Resident #6. Resident #6 was admitted to the facility 4/20/16 with diagnoses, which included but were not limited to: anxiety disorder, arthritis, depression,	F 695		

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F 695	Continued From page 40 diabetes, high blood pressure, and dementia. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/28/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as having used oxygen within the last 14 days of the look back period. Observation was made of Resident #6 on 8/22/18 at 8:06 a.m. The resident was in bed with her oxygen on via the nasal cannula (plastic tube with two prongs that insert into the nose), connected to an oxygen concentrator. The oxygen concentrator was set at 4L/min (liters/minute). A second observation was made of Resident #6 on 8/22/18 at 9:48 a.m. The resident was still in the bed with her oxygen on via the nasal cannula connected to an oxygen concentrator. The oxygen concentrator was set at 4L/min. On 8/22/18 at 9:50 a.m., the oxygen concentrator was observed with LPN (licensed practical nurse) #3. LPN #3 verified that the oxygen flow meter was set at 4L/min. LPN #3 stated he did not have any residents prescribed for 4 liters. He stated she probably is supposed to be on 2 liters. LPN #3 went to the clinical record and verified the resident was to be on 2L/min per the physician order.	F 695		

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F 695	Continued From page 41 The physician order dated, 8/7/18, documented, "O2 (oxygen) @ (at) 2L/m (liters per minute) via nasal cannula at HS (hours of sleep - bedtime) per resident request. Remove O2 at 2L/min NC (nasal cannula) QAM (every morning)." The August 2018 "Treatment Administration Record" (TAR) documented the above physician order. The TAR documented the administration of the oxygen every evening for each evening in August. There was no documented nurse's notes for 8/22/18. The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: At risk for SOB (shortness of breath) due to DX (diagnosis) of COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1)." The "Approaches" documented in part, "O2 as ordered." The facility policy, "Oxygen Administration" documented in part, "Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration...Steps in Procedure: 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, LPN (licensed practical nurse) #1, the assistant director of nursing, and ASM #5, the administrator	F 695		

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F 695	Continued From page 42 in training, were made aware of the above concern on 8/22/18 at 6:00 p.m. No further information was provided prior to exit.	F 695		10/1/18
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a resident was free of unnecessary medications for one of 31 residents in the survey sample, Resident #11. Resident #11 received a higher dose of Novolog	F 757	**F757** **Corrective Action(s):** Resident #11's attending physician has been notified that the facility administered an incorrect dose of insulin when performing a sliding scale blood sugar check per physician order. A facility Medication error form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Physician ordered Insulin may have potentially been affected. A 100% review of all residents with insulin orders will be conducted by DON and/or designee to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of insulin to include administering sliding scale insulin as ordered by the physician and following all blood sugar parameters as ordered by the physician.	

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F 757	Continued From page 43 insulin (a short acting insulin (1)) then what was prescribed by the physician for a blood sugar reading of 348 on 8/4/18 at 11:30 a.m. The findings include: Resident #11 was admitted to the facility on 7/21/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, anxiety disorder and mild cognitive impairment. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring no assistance to limited assistance for her activities of daily living. The physician order dated, 6/7/18, documented, "BS (blood sugar) AC (before) meals w/ (with) Novolog (a short acting insulin (1)) SQ (subcutaneous) Sliding Scale: Below 130 = O (units) 131 - 180 = 4 u (units) 181 - 240 = 8 u 241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 400 = 20 u & (and) call MD (medical doctor)." The August 2018 MAR (medication administration record) documented the above order. On 8/4/18 at 11:30 a.m., the nurse documented the blood sugar as "348." The documented amount of	F 757	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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F 757	Continued From page 44 insulin administered was "16." The next recorded blood sugar on 8/4/18 at 4:30 p.m. documented the blood sugar as "74." The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: Diabetes Mellitus risk for high and lows of BS. Resident predicts her needs and intake based on how she thinks she is feeing vs (versus) actual number of glucose readings." The "Approaches" documented in part, "Give medications per orders. BS per order. Notify MD of changes in BS or s/s (signs and symptoms) of hypo/hyperglycemia (too low or too high blood sugars)." An interview was conducted with LPN (licensed practical nurse) #3, on 8/23/18 at 8:22 a.m. When asked if physician orders for sliding scale insulin for blood sugars should be followed, LPN #3 stated, "Absolutely." An interview was conducted with LPN #6, the nurse that gave the insulin on 8/4/18 at 1:30 a.m., on 8/23/18 at 10:02 a.m. The above order for insulin was read to LPN #6. When asked what amount of insulin per the order, should the resident have received, for the blood sugar reading of 348, LPN #6 stated, "12 units." The MAR for August of 2018 was reviewed with LPN #6 and her documentation of administering "16" units. LPN #6 stated, "That was an error." When asked if that was following the physician's order, LPN #6 stated, "No, I made a mistake." The blood sugar on 8/4/18 at 4:30 p.m. was shared with LPN #6. LPN #6 stated, "I didn't realize I did that. That's a mistake and I am responsible." The facility policy, "Administering Mediations,"	F 757		

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F 757	Continued From page 45 documented in part, "Medications shall be administered in a safe and timely manner, and as prescribed...7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication...20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered. b. The dosage. c. The route of administration. d. The injection site (if applicable)...g The signature and title of the person administering the drug." According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg 707 reads: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m.	F 757		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 46 (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=cd88e313-6193-4413-beff-7d955580060d	F 757		10/1/18
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(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 the facility staff failed to ensure a resident was free of a significant medication error for one of 31 residents in the survey sample, Resident #11. The facility staff administered four more units of Novolog insulin (a short acting insulin (1)) to Resident #11, than what the physician's orders documented for a blood sugar reading of 348. The findings include: Resident #11 was admitted to the facility on 7/21/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, anxiety disorder and mild cognitive impairment. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily	F 760	**F760** **Corrective Action(s):** Resident #11's attending physician has been notified that the facility administered 4 more units of insulin than was ordered per the sliding scale insulin order. LPN #6 involved in administrating the incorrect insulin dose has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving may have potentially been affected. A 100% medication pass audit will be conducted with all licensed nurses to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action and inservice training will be administered as warranted. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed Nursing staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of sliding scale insulin per physician order.	

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	495301	A. BUILDING _____ B. WING _____	C 08/23/2018

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F 760	Continued From page 47 decisions. The resident was coded as requiring no assistance to limited assistance for her activities of daily living. The physician order dated, 6/7/18, documented, "BS (blood sugar) AC (before) meals w/ (with) Novolog SQ (subcutaneous) Sliding Scale: Below 130 = O (units) 131 - 180 = 4 u (units) 181 - 240 = 8 u 241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 400 = 20 u & (and) call MD (medical doctor)." The August 2018 MAR (medication administration record) documented the above order. On 8/4/18 at 11:30 a.m., the nurse documented the blood sugar as "348." The documented amount of insulin administered was "16." The next recorded blood sugar on 8/4/18 at 4:30 p.m. documented the blood sugar as "74." The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: Diabetes Mellitus risk for high and lows of BS. Resident predicts her needs and intake based on how she thinks she is feeing vs (versus) actual number of glucose readings." The "Approaches" documented in part, "Give medications per orders. BS per order. Notify MD of changes in BS or s/s (signs and symptoms) of hypo/hyperglycemia (too low or too high blood sugars)." An interview was conducted with LPN (licensed practical nurse) #3, on 8/23/18 at 8:22 a.m. When asked if physician orders for sliding scale insulin	F 760	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will perform 2 random weekly Medication Pass audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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F 760	Continued From page 48 for blood sugars should be followed, LPN #3 stated, "Absolutely." An interview was conducted with LPN #6, the nurse that gave the insulin on 8/4/18 at 1:30 a.m., on 8/23/18 at 10:02 a.m. The above order for insulin was read to LPN #6. When asked what amount of insulin per the order, should the resident have received, for the blood sugar reading of 348, LPN #6 stated, "12 units." The MAR for August of 2018 was reviewed with LPN #6 and her documentation of administering "16" units. LPN #6 stated, "That was an error." When asked if that was following the physician's order, LPN #6 stated, "No, I made a mistake." The blood sugar on 8/4/18 at 4:30 p.m. was shared with LPN #6. LPN #6 stated, "I didn't realize I did that. That's a mistake and I am responsible." The facility policy, "Administering Mediations," documented in part, "Medications shall be administered in a safe and timely manner, and as prescribed...7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication...20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered. b. The dosage. c. The route of administration. d. The injection site (if applicable)...g The signature and title of the person administering the drug." According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg 707	F 760		

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F 760	Continued From page 49	F 760		

reads: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation."

"NOVOLOG ... is a rapid-acting human insulin analog used to lower blood glucose."..."5.3 Hypoglycemia is the most common adverse effect of all insulin therapies, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness may be life threatening or cause death." "10 OVERDOSAGE: Excess insulin administration may cause hypoglycemia and hypokalemia. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. Sustained carbohydrate intake and observation may be necessary because hypoglycemia may recur after apparent clinical recovery. Hypokalemia must be corrected appropriately." (2)

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern

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F 760	Continued From page 50 on 8/23/18 at 9:50 a.m. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd88e313-6193-4413-beff-7d955580060d (2) This information was obtained from the webiste:https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5	F 760		10/1/18
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842	**F842** **Corrective Action(s):** Resident #11 attending physicians has been notified that the facility failed to notify the physician of an elevated blood sugar per physician order and did not accurately document blood sugar results in the Medication administration record. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all resident Medical Records will be conducted by the DON, ADON, and or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff, Social Services director, Activity Director and dietary manager	

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F 842	Continued From page 51 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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	F 842	will be inserviced by the Regional Nurse Consultant or DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and departmental notes according to the acceptable professional standards and practices. **Monitoring:** The DON and Medical Records director are responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10/1/18**	

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F 842	Continued From page 52 (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, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 31 residents in the survey sample, Resident #11. A. The facility staff failed to document the notification of the physician for an elevated blood sugar for Resident #11. B. The facility staff failed to document the actual blood sugar readings for Resident #11. The findings include: A. Resident #11 was admitted to the facility on 7/21/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, anxiety disorder and mild cognitive impairment. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as requiring no assistance to limited assistance for her activities of daily living. The physician order dated, 6/7/18, documented, "BS (blood sugar) AC (before) meals w/ (with) Novolog (a short acting insulin) (1) SQ (subcutaneous) Sliding Scale:	F 842		

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F 842	Continued From page 53 Below 130 = O (units) 131 - 180 = 4 u (units) 181 - 240 = 8 u 241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 400 = 20 u & (and) call MD (medical doctor)." The June 2018 Medication Administration Record (MAR) documented the above medication order. On 6/26/18 at 4:30 p.m., the nurse documented the blood sugar as "436." Review of the MAR notes and the nurse's notes failed to evidence documentation of physician notification. RN (registered nurse) #2 documented this. The comprehensive care plan dated, 5/30/18, documented in part, "Problem/Need: Diabetes Mellitus risk for high and lows of BS. Resident predicts her needs and intake based on how she thinks she is feeing vs (versus) actual number of glucose readings." The "Approaches" documented in part, "Give medications per orders. BS per order. Notify MD of changes in BS or s/s (signs and symptoms) of hypo/hyperglycemia (too low or too high blood sugars)." An interview was conducted with RN #2 on 8/22/18 at 6:46 p.m. RN #2 was asked to review the above order for sliding scale insulin. She was asked to review the MAR for 6/26/18. When asked if she notified the doctor of the blood sugar, RN #2 stated, "I know I did it. I wrote it in her (the doctor's) communication book." RN #2 further stated, "I've been doing this for a long time. If it's not documented, I may have hit cancel or enter and it disappeared but I know I did it." RN	F 842		

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F 842	Continued From page 54	F 842		

#2 was asked to provide evidence that she documented the notification in the doctor's communication book.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 8/23/18 at 8:10 a.m. The blood sugar and nurse's notes were reviewed with ASM #2. When asked if they had found documentation of the notification in the doctor's communication book, ASM #2 stated they had not found it. ASM #2 further stated, "If it's not documented it's not done."

An interview was conducted with LPN (licensed practical nurse) #3 on 8/23/18 at 8:20 a.m. When asked if the physician ordered sliding scale should be followed as written, LPN #3 stated, "Absolutely." when asked if the blood sugar is greater than 400 and you notify the doctor, where is the notification documented, LPN #3 stated, "In the nurse's notes."

On 8/23/18 at 8:56 a.m. presented a document of blood sugars for Resident #11 that was printed on 6/27/18 at 6:32 a.m. The attending physician signed the paper. LPN #1 stated, "We print these out on the 11-7 (11:00 p.m. to 7:00 a.m.) shift for the doctors and nurse practitioners for the days they are coming to the facility." When asked if this document is part of the clinical record, LPN #1 stated, "No, Ma'am."

The facility policy, "Charting and Documentation" documented in part, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication

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F 842	Continued From page 55 between the interdisciplinary team regarding the resident's condition and response to care...2. The following information is to be documented in the resident medical record: a. Objective observations. b. Medications administered. c. Treatments or services performed. d. Changes in the resident's condition. e. Events, incidents or accidents involving the resident. f. Progress toward or changes in the care plan goals and objectives." The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received ...Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd88e313-6193-4413-beff-7d955580060d B. The facility staff failed to document the actual blood sugar readings for Resident #11. The July 2018 MAR documented the order for the	F 842		

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F 842	Continued From page 56 sliding scale insulin above. On 7/7/18, 7/8/18 and 7/22/18 at 4:30 p.m. there was no documented blood sugar reading. RN # 1 completed all three dates. The July 2018 MAR notes documented the following on each of the above dates: "scheduled for 4:30 p.m. bs (blood sugar) < (less than) 130." Review of the "Vital Signs" section of the electronic record failed to evidence documentation of the blood sugar readings on the above dates and times. Review of the nurse's notes for the above dates failed to evidence documentation of the blood sugar readings. An interview was conducted with RN #1 on 8/22/18 at 6:25 p.m. The above MAR was reviewed with RN #1. When asked how the blood sugar reading numbers are entered into the system, RN #1 stated, "A box pops up and you put in the reading." When asked if the actual number for the blood sugar reading should be included in the MAR, RN #1 stated, "I don't know why it isn't there." An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 8/23/18 at 8:10 a.m. The blood sugar and nurse's notes were reviewed with ASM #2. When asked if they had found documentation of the physician notification in the doctor's communication book, ASM #2 stated they had not found it. ASM #2 further stated, "If it's not documented it's not done." An interview was conducted with LPN #3 on	F 842		

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F 842	Continued From page 57 8/23/18 at 8:20 a.m. When asked where the blood sugar readings are documented, LPN #3 stated, "A box comes up and you put it there. It then populates to the blood sugar section in the vital signs." When asked if a nurse should document the blood sugar as less than 130, LPN #3 stated, "It's probably not in the best interest to do that." The facility policy, "Obtaining a Finger stick Glucose Level" documented in part, "Documentation...The person performing this procedure should record the following information in the resident's medical record:..6. The blood sugar results." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m.	F 842		10/1/18
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(1) A system for preventing, identifying,	F 880	**F880** **Corrective Action(s):** The attending physician for Resident #34 was notified that RN#2 touched the inside of the resident's medication cup with her bare fingers prior to medication administration. A facility Incident & Accident form has been completed for each of this incident. RN#2 has received one on one inservice training on proper medication administration by the DON. The attending physician for Residents #198 & #21 was notified that RN#1 touched the inside of the resident's medication cups with her bare fingers prior to administration. A facility Incident & Accident form has been completed for each of this incident. RN#1 has received one on one inservice training on proper medication administration by the DON.	

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F 880	Continued From page 58 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; §483.80(a)(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 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	The attending physician for resident #96 was notified that the facility failed to ensure contact precautions were implemented when caring for resident #96. CNA #1 has been inserviced by the DON on the proper contact isolation procedure to be utilized when assisting residents on isolation precautions. An Incident & Accident form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected by improper infection control and medication pass techniques. The DON and/or Unit Manager will conduct medication pass audits on all licensed staff to observe proper infection control practices and proper medication administration procedures. The DON, ADON and/or Unit Manager will conduct audits on residents on isolation to observe proper infection control practices, proper PPE use and hand washing during resident care. Any negative findings will be addressed immediately, and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding **Systemic Change(s):** The facility Infection Control policy and medication administration policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or Regional Nurse Consultant will inservice all licensed staff on the proper medication administration	

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F 880	Continued From page 59 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices for three of seven residents in the medication administration observation, Resident #34, 198 and #21; and for one of 31 residents in the survey sample, Resident #96. 1. The facility staff failed to ensure the medication cup for Resident #34 was free from contamination during medication pass. 2. The facility staff failed to ensure the medication cups for Resident #198 and #21, were free from contamination during medication pass. 3. The facility staff failed to implement physician ordered contact precautions while in Resident #96's room. The findings include: 1. Resident #34 was admitted to the facility 8/18/06 with diagnoses that included but were not limited to cerebrovascular disease (stroke),	F 880	procedures to be followed during medication administration. All nursing staff will be inserviced on the facility policy and procedure on infection control to include the proper use of PPE for residents on isolation by the DON, ADON and/or Regional Nurse Consultant. **Monitoring:** The DON are responsible for maintaining compliance. The DON, ADON and/or designee will perform 2 random Medication pass audits to monitor for compliance with medication administration and supplement administration. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. The DON, ADON and/or Unit Manager will perform random weekly audits of residents on isolation precautions to monitor nursing staff for compliance. Any negative findings will be addressed at time of discovery and disciplinary action taken as warranted Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Completion Date: 10/1/18**	

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F 880	Continued From page 60 COPD (chronic obstructive pulmonary disease), and high blood pressure. Resident #34's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/10/18. Resident #34 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #34 was coded as requiring limited assistance from one staff member with bed mobility and transfers; extensive assistance from one staff member with dressing, and personal hygiene; total dependence on staff with toileting and bathing. On 8/22/18 at 5:07 p.m., medication administration was conducted with RN (registered nurse) #2. RN #2 was observed preparing the following medications for Resident #34: (1) Neurontin 100 mg (milligrams) capsule (2) Zantac 150 mg tablet After these medications were prepared, RN #2 grabbed the rim of the medication cup with her bare fingers and transported the medication to Resident #34's room. RN #2 gave the cup to Resident #34, and he took the medications. Resident #34's lips were touching the rim of the cup, where RN #2's bare fingers had touched. On 8/22/18 at 5:14 p.m., an interview was conducted with RN #2. When asked how nurses should hold the medication cup while preparing and transporting medications, RN #2 demonstrated that her fingers should be around the middle of the cup. When asked if nurses could hold the cup by the rim, RN #2 stated that fingers should not be near the rim or inside of the	F 880		

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F 880	Continued From page 61 cup. RN #2 stated that holding the cup by the rim would result in contamination. RN #2 was made aware the above observations. RN #2 stated she did not realize that she had held the medication cup by the rim. RN #2 stated that she should not have done that. On 8/22/18 at 6:22 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Administering Medications," documented in part, the following: "Staff shall follow established facility infection control procedures (e.g. handwashing, antispetic technique, gloves, isolation, precautions, etc.) for the administration of medications, as applicable." No further information was presented prior to exit. (1) Neurontin is used for the treatment of seizures and helps to relieve nerve pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010419/?report=details. (2) Zantac used to treat and relieve heartburn. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011947/. 2. The facility staff failed to ensure the medication cups for Resident #198 and #21, were	F 880		

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F 880	Continued From page 62 free from contamination during medication pass. Resident #198 was admitted to the facility on 8/17/18 with diagnoses that included but were not limited to left artificial knee joint, high blood pressure, and high cholesterol. Resident # 198 did not have a completed MDS (minimum data set) assessment and was documented as being alert and oriented x 3 (person, place, time). Resident #21 was admitted to the facility with diagnoses that included but were not limited to heart failure, dementia without behavioral disturbance, and high blood pressure. Resident #21's most recent MDS (minimum data set) assessment was a five day scheduled assessment with an ARD (assessment reference date) of 8/10/18. Resident #21 was coded as severely cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. On 8/22/18 at 5:20 p.m., medication administration was conducted with RN (registered nurse) #1. RN #1 was observed preparing the following medications for Resident #198: (1) Aspirin 325 mg (milligrams) - 1 tablet (2) Norco 5/325 mg- 1 tablet After these medications were prepared, RN #1 grabbed the rim of the medication cup with her bare fingers and transported the medication to Resident #198s room. RN #1 gave the cup to Resident #198, and he took the medications. Resident #198's lips were touching the rim of the cup, where RN #1's bare fingers had touched. RN #1 then threw away the medication cup and washed her hands. RN #1 then proceeded to	F 880		

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F 880	Continued From page 63 prepare Resident #21's medications. On 8/22/18 at 5:30 p.m., RN #1 grabbed an empty medication cup, her bare fingers touching the rim of the cup, and a packet of Pro-Stat (3) protein powder and proceeded to Resident #21's room. RN #1 then placed the medication cup on Resident #21's over bed table and emptied the contents of the Pro-Stat into the cup, mixing it with water. RN #1 then picked up the medication cup by the rim of the cup, with her bare fingers and gave the cup to Resident #21. Resident #21 drank the Pro-Stat liquid. Resident #21's lips touched the rim of the cup, where RN #1's bare fingers had touched. RN #1 then washed her hands. On 8/22/18 at 5:35 p.m., an interview was conducted with RN #1. When asked how nurses should hold the medication cup while preparing and transporting medications, RN #1 stated that the top and the inside of the cup should not be touched to avoid contamination. When asked if she touched the rim of Resident #198's and Resident #21's medication cup with her bare fingers, RN #1 stated that she was not sure. RN #1 was then made aware of the above observations. RN #1 stated that she was not aware that she had done that. RN #1 stated that it was an infection control issue to touch the rim of the medication cup. On 8/22/18 at 6:22 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 880		

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F 880	Continued From page 64 (1) Aspirin- "Used to decrease mild to moderate pain associated with inflammatory disorders." This information was obtained from Davis's Drug Guide, 11th edition, p. 1087. (2) Norco- "Opioid analgesic used to treat pain." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details. (3) Pro-Stat- Supplemental protein used for wound healing. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495749/. 3. The facility staff failed to implement physician ordered contact precautions while in Resident #96's room. Resident #96 was admitted to the facility on 12/20/16. Resident #96's diagnoses included but were not limited to convulsions, diabetes and urinary tract infection. Resident #96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/18, coded the resident as being cognitively intact. Review of Resident #96's clinical record revealed a physician's order dated 8/15/18 for contact isolation due to ESBL (Extended-spectrum ß-lactamase (1)). Resident #96's comprehensive care plan dated 6/11/18 documented, "CI (Contact isolation) (2) for MRSA (3) and ESBL in urine...Approaches: Contact isolation..." Resident #96's CNA (certified nursing assistant)	F 880		

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F 880	Continued From page 65 care plan failed to document information regarding contact isolation. On 8/22/18 at 8:28 a.m., CNA #1 was observed in Resident #96's room and assisting the resident with a beverage. CNA #1 was not wearing a gown, mask or gloves. CNA #1 did not wash her hands before leaving the room. On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked what she should do before entering and when leaving a contact isolation room. LPN #5 stated, "I'm going to use my protective gear which should be outside the room; put on whatever is suitable for the isolation. Knock on the door ask to enter the room. Before I leave, once I have done what I need to do, remove my stuff at the door to be able to wash my hands to leave the room." On 8/22/18 at 2:12 p.m., an interview was conducted with CNA #1. CNA #1 was asked what she should do before entering a contact isolation room. CNA #1 stated, "Gown up, mask and gloves." CNA #1 was asked what she should do before leaving a contact isolation room. CNA #1 stated, "Take it off, put it in the isolation carts in the room" When asked if she should wash her hands, CNA #1 stated, "Uh huh." On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings. The facility document titled, "Isolation- Categories of Transmission-Based Precautions"	F 880		

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F 880	Continued From page 66	F 880		

documented, "Contact Precautions; 1. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...4. Gloves and Handwashing: In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). Remove gloves before leaving the room and perform hand hygiene. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. 5. Gown: Wear a disposable gown upon entering the Contact Precautions room or cubicle. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces..."

No further information was presented prior to exit.

(1) "Extended-spectrum ß-lactamase is an enzyme that allows bacteria to become resistant to a wide variety of penicillins and cephalosporins. Bacteria that contain this enzyme are known as ESBLs or ESBL-producing bacteria. ESBL-producing Enterobacteriaceae are resistant to strong antibiotics including extended spectrum cephalosporins." This information was obtained from the website: https://www.cdc.gov/drugresistance/biggest_threats.html

(2) "Healthcare personnel caring for patients on

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F 880	Continued From page 67 Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf (3) "Methicillin-resistant Staphylococcus aureus (MRSA) causes a range of illnesses, from skin and wound infections to pneumonia and bloodstream infections that can cause sepsis and death. Staph bacteria, including MRSA, are one of the most common causes of healthcare-associated infections." This information was obtained from the website: https://www.cdc.gov/drugresistance/biggest_threats.html	F 880		10/1/18