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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted on 5/14/19 through 5/16/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 05/14/2019 through 05/16/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey.<br><br>The census in this 90 certified bed facility was 78 at the time of the survey. The survey sample consisted of 37 resident reviews. | F 000 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including | F 583 | | 6/7/19 |

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

Electronically Signed | 06/01/2019

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| F 583 | Continued From page 1<br>the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to maintain confidentiality of a clinical record for one of 37 residents in the survey sample, Resident #23.<br><br>LPN (Licensed practical nurse) #2 failed to maintain confidentiality of Resident #23's MAR (medication administration record) on 5/15/19. LPN #2 left the resident's MAR open on the medication cart in the hall while in a resident's room.<br><br>The findings include:<br><br>Resident #23 was admitted to the facility on 6/25/18. Resident #23's diagnoses included but were not limited to muscle weakness, anxiety disorder and repeated falls. Resident #23's most recent MDS (minimum data set), a quarterly | F 583 | 1. LPN #2 closed MAR at the time surveyor brought to her attention. LPN #2 was educated on HIPAA privacy policies.<br><br>2. All residents who receive medications have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on HIPAA privacy policies.<br>Newly hired employees will receive education on HIPPA privacy policies during facility orientation program.<br><br>4. Administrator or designee will complete audit on HIPAA privacy policy compliance by clinical walkthrough. Audits will be completed 5x weekly for 4 weeks, then 3x | |

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| F 583 | Continued From page 2 | F 583 | | |

assessment with an ARD (assessment reference date) of 3/22/19, coded the resident as being cognitively intact. Resident #23's comprehensive care plan dated 6/26/18 failed to document specific information regarding confidentiality of the clinical record.

On 5/15/19 at 8:37 a.m., LPN #2 was observed preparing and administering medications. LPN #2 left Resident #23's MAR open on the medication cart in the hall while in another resident's room. The MAR contained information such as Resident #23's prescribed medications and diagnoses. Other staff were observed in the hall.

On 5/15/19 at 8:56 a.m., an interview was conducted with LPN #2. LPN #2 was asked what should be done with the MAR on top of the medication cart in the hall when she leaves the medication cart to enter a resident's room. LPN #2 stated, "You always close it." When asked why, LPN #2 stated, "HIPAA (heath insurance portability and accountability act) (1)." When made aware of the above observation, LPN #2 stated she thought she closed the MAR before entering the resident's room.

On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility policy titled, "HIPAA Privacy Policy Overview and Definitions" failed to document specific information regarding maintaining confidentiality of the MAR.

weekly for 4 weeks, and then 2x weekly for 4 weeks.
Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation.

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| F 583 | Continued From page 3<br>No further information was presented prior to exit.<br><br>(1) "The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information.1 To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form..." This information was obtained from the website: https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html | F 583 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable | F 656 | | 6/7/19 |

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| F 656 | Continued From page 4<br>physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 37 residents in the survey sample, Residents #11, #64 and #10.<br><br>1. The facility staff failed to implement Resident #11's comprehensive care plan for the administration of constipation medication. | F 656 | 1. Care plan for resident #11, #64, and #10 was reviewed for accuracy and associated revision.<br><br>2. All residents have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on following resident care plan. | |

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| F 656 | Continued From page 5<br><br>2. The facility staff failed to implement Resident #64's comprehensive care plan for the administration of constipation medication.<br><br>3. The facility staff failed to implement Resident #10's comprehensive care plan for the use of Dycem (1) in the wheelchair to prevent a fall on 2/6/19.<br><br>The findings include:<br><br>1. The facility staff failed to implement Resident #11's comprehensive care plan for the administration of constipation medication.<br><br>Resident #11 was admitted to the facility on 7/14/17. Resident #11's diagnoses included but were not limited to high blood pressure, anxiety disorder and chronic pain syndrome. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/27/19, coded the resident's cognition as severely impaired.<br><br>Resident #11's comprehensive care plan dated 6/28/18 documented, "At risk for constipation/dehydration r/t (related to) decreased mobility, weakness...Interventions: meds (medications) as ordered..."<br><br>On 5/15/19 at 8:25 a.m., LPN #1 was observed preparing and administering medications to Resident #11. LPN #1 prepared and administered to Resident #11 two tablets of Colace with Senna 50 mg/8.6 mg.<br><br>Review of Resident #11's clinical record revealed a physician's order dated 7/14/17 for Colace 100 | F 656 | Newly hired employees will receive education on following resident care plan during facility orientation program.<br><br>4. MDS coordinator or designee will audit 5 resident care plans weekly to ensure proper care plan implementation for 12 weeks.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| F 656 | Continued From page 6 | F 656 | | |

mg- one cap by mouth twice daily for constipation. Further review of physician's orders failed to reveal an order for Senna. Review of Resident #11's May 2019 MAR (medication administration record) revealed a physician's order dated 7/14/17 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of the MAR failed to reveal an order for Senna.

On 5/15/19 at 12:41 p.m., an interview was conducted with LPN #1. LPN #1 was asked about the facility process for ensuring the correct medication is administered. LPN #1 stated, "You compare the medication to the MAR, make sure it's the correct patient, make sure it's the correct dose." LPN #1 was made aware Resident #11 had a physician order for 100 mg of Colace but she was observed preparing and administering two tablets of Colace with Senna to the resident. LPN #1 confirmed she should not have administered the Colace with Senna. When asked what medication should have been administered, LPN #1 stated she should have administered 100 mg of Colace without Senna. LPN #1 was asked about the facility process to ensure nurses implement residents' care plans for medication administration. LPN #1 stated, "There is certain particular times we have; again, make sure it's the correct resident, right time, right dose, right frequency and sometimes we will reference to the pos (physician order summary) if we have any questions or concerns."

On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

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| F 656 | Continued From page 7 | F 656 | | |

The facility policy titled, "Care Plan" documented, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

No further information was presented prior to exit.

(1) Colace is a stool softener used to relieve constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601113.html

(2) Colace with Senna is a combination medication containing Colace (a stool softener) and Senna (a laxative) and is used to treat constipation. This information was obtained from the websites: https://medlineplus.gov/druginfo/meds/a601113.html and https://medlineplus.gov/druginfo/meds/a6011122.html

2. The facility staff failed to implement Resident #64's comprehensive care plan for the administration of constipation medication.

Resident #64 was admitted to the facility on 5/4/10. Resident #64's diagnoses included but were not limited to muscle weakness, difficulty swallowing and anxiety disorder. Resident #64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/1/19, coded the resident's cognition as moderately impaired.

Resident #64's comprehensive care plan dated 4/15/19 documented, "At risk for

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| F 656 | Continued From page 8 | F 656 | | |

constipation/dehydration r/t (related to) decreased mobility, weakness...Interventions: meds (medications) as ordered..."

On 5/15/19 at 8:17 a.m., LPN #1 was observed preparing and administering medications to Resident #64. LPN #1 prepared and administered to Resident #64, two tablets of Colace with Senna 50 mg/8.6 mg.

Review of Resident #64's clinical record revealed a physician's order dated 4/3/19 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of physician's orders failed to reveal an order for Senna. Review of Resident #64's May 2019 MAR (medication administration record) revealed a physician's order dated 4/3/19 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of the MAR failed to reveal an order for Senna.

On 5/15/19 at 12:41 p.m., an interview was conducted with LPN #1. LPN #1 was asked about the facility process for ensuring the correct medication is administered. LPN #1 stated, "You compare the medication to the MAR, make sure it's the correct patient, make sure it's the correct dose." LPN #1 was made aware Resident #11 had a physician order for 100 mg of Colace but she was observed preparing and administering two tablets of Colace with Senna to the resident. LPN #1 confirmed she should not have administered the Colace with Senna. When asked what medication should have been administered, LPN #1 stated she should have administered 100 mg of Colace without Senna. LPN #1 was asked about the facility process to ensure nurses implement residents' care plans

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| F 656 | Continued From page 9 | F 656 | | |

for medication administration. LPN #1 stated, "There is certain particular times we have; again, make sure it's the correct resident, right time, right dose, right frequency and sometimes we will reference to the pos (physician order summary) if we have any questions or concerns."

On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

(1) Colace is a stool softener used to relieve constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601113.html

(2) Colace with Senna is a combination medication containing Colace (a stool softener) and Senna (a laxative) and is used to treat constipation. This information was obtained from the websites: https://medlineplus.gov/druginfo/meds/a601113.html and https://medlineplus.gov/druginfo/meds/a6011122.html

3. The facility staff failed to implement Resident #10's comprehensive care plan for the use of Dycem (1) in the wheelchair to prevent a fall on 2/6/19.

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Resident #10 was admitted to the facility on 8/24/18 with the diagnoses of, but not limited to, depression, irritable bowel syndrome, and chronic kidney disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/22/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living and was coded as incontinent of bowel and bladder.

A review of the physician's orders revealed one dated 1/7/19 for "Dycem to w/c (wheelchair) dx (diagnosis): fall prevention."

A review of the comprehensive care plan revealed one dated 9/3/18 for falls, which included the intervention, "Dycem in w/c." This intervention was dated 1/17/19.

A nurse's note dated 2/6/19 at 10:05am, written by RN #1 (Registered Nurse) which documented the following: "Resident was noted on the floor in front of her wheelchair apparently slid from the wheelchair, no injuries visible....Resident has dementia with confusion and is unable to say what she was attempting at the time of her fall. Resident was assisted off the floor by staff x 2 with gait belts. RP (Responsible Party) and MD (Medical Doctor) are aware. Immediate Intervention: Resident was brought to the nurses station for supervision....Resident has full range of motion to all extremities. Neurological checks are within normal limits. Resident has no c/o (complaints of) pain. Pain level is 0 out of 10. Resident skin tone normal. Skin is warm and dry....no visible injury...."

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Further review revealed another nurse's note dated 2/6/19 at 11:43am, also written by RN #1, which documented, "Resident was noted on the floor in front of her chair apparently slid from her wheelchair. Resident had dementia with confusion and impulsiveness. She is unable to state what she was attempting at the time of her fall. ROM (range of motion) is within limits VSS (vital signs stable). Resident was placed back into her wheelchair by staff assistance x 2 with gait belts. No visible injury noted. RP and MD are aware."

A review of the facility incident report for the above fall on 2/6/19 documented, "Resident was noted on the floor in her room apparently slid from her wheel chair. Resident does not know what she was attempting to do dycem {sic} was not noted to her wheelchair."

On 5/16/19 at 12:00 p.m., in an interview with RN (registered nurse) #1. When asked about the physician ordered intervention of Dycem in the wheelchair to prevent falls not being in place at the time of this fall, RN #1 stated that the resident is impulsive and picks at things and might have removed it before she was transferred to her chair. When asked if staff should be checking for the placement of the Dycem before transferring the resident to the wheelchair, RN #1 stated, "We don't check with every transfer." When asked about the process staff are to follow for checking for the Dycem, RN #1 stated, "I believe the expectation is to check when we clean the chairs every week." When asked if it is an expectation to ensure a physician ordered device for the prevention of a fall is in place prior to transferring the resident, RN #1 stated, "It isn't ordered to be checked with every transfer." When asked if the

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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 |
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| F 656 | Continued From page 12<br>care plan was followed regarding the use of the Dycem, RN #1 stated, "I can't say that it wasn't followed."<br><br>On 5/16/19 at 12:14pm in an interview with ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing), ASM #2 stated that the placement of the Dycem should be checked with each transfer. When asked if the physician's order for the use of Dycem to prevent falls was followed, ASM #2 stated it was not. When asked if the care plan intervention for the use of the Dycem to prevent falls was followed, ASM #2 stated it was not.<br><br>A review of the facility policy, "Care Plan" documented, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."<br><br>No further information was provided by the end of the survey.<br><br>1. Dycem is a polymer with very high grip properties...that can be used on seats to help prevent the patient sliding off seats which can result in injury or fractured hips.<br>This information obtained from https://dycem-ns.com/about-us and https://dycem-ns.com/uses-for-dycem-non-slip | F 656 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive | F 684 | | 6/7/19 |

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| F 684 | Continued From page 13<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation and clinical review, it was determined that the facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for one of 37 residents in the survey sample: Resident #419.<br><br>The facility staff failed to administer physician prescribed medications to Resident #419 per the physician's orders on 5/12/19 and 5/13/19.<br><br>The findings include:<br><br>Resident #419 was admitted to the facility on 5/2/19. Resident #419's diagnoses included but were not limited to: muscle weakness, retention of urine and high cholesterol. Resident #419's most recent MDS (minimum data set), an admission and 5-day Medicare assessment with an ARD (assessment reference date) of 5/2/19, coded the resident's cognition as moderately impaired.<br><br>Review of Resident #419's clinical record revealed a physician's order summary signed by the physician on 5/12/19. The summary contained the following physician order: 5/2/19 - Aminocaproic Acid (1) 500 mg (milligram) - two tabs (tablets) by mouth every six hours for bleeding prevention. | F 684 | 1. Physician & resident responsible party were notifies of facility not following physician orders for resident #419.<br><br>2. All residents have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on following physician orders.<br>Newly hired employees will receive education on following physician orders during facility orientation program.<br><br>4. Unit Manager or designee will audit 10 resident's MAR/TAR weekly for 12 weeks to ensure nursing staff are following physician orders.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| F 684 | Continued From page 14 | F 684 | | |

Review of Resident #419's May 2019 medication administration record (MAR) revealed Aminocaproic Acid was not administered to Resident #419 on 5/12/19 at 12:00 a.m., 12:00 p.m. and 6:00 p.m. and 5/13/19 at 12:00 a.m. 6:00 a.m., 12:00 p.m. and 6 p.m. On 5/12/19, the medication administration notes documented, "Need order to be checked with urology." On 5/13/19, the MAR (medication administration record) notes documented, "Not covered. Nurse Practitioner made aware." Review of the pharmacy manifest revealed that this medication (quantity 40 tablets) was delivered to the facility on 5/3/19.

Resident #419's comprehensive care plan with a reference date of 5/10/19 failed to document specific information regarding the above medication.

On 5/16/19 at 9:30 a.m., an interview was conducted with LPN #2 (the nurse responsible for administering Aminocaproic Acid to Resident #419 on 5/12/19 at 12:00 p.m. and 5/13/19 at 12:00 p.m.) LPN #2 was asked why the medication was not administered when the medication was delivered to the facility on 5/3/19. LPN #2 stated that the medications were misplaced with another resident's medication and later found on 5/15/19. The nurses responsible for administering medication on 5/12/19 at 6:00 p.m. and 5/13/19 at 12:00 a.m. and 6:00 p.m. were unavailable for interview.

A review of the facility policy titled, "General Dose Preparation and Medication Administration" documented, "Medications should be administered within timeframes specified by

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| F 684 | Continued From page 15<br>facility policy."<br><br>On 5/16/19 at 10 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern.<br><br>No information was presented prior to exit.<br><br>(1) Aminocaproic Acid - a medication used to control bleeding that occurs when clots are broken down too quickly. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a608023.html | F 684 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to prevent accidents and hazards for 1 of 37 residents in the survey sample; Resident #10.<br><br>The facility staff failed to follow physician's orders and the comprehensive care plan for the use of Dycem (1) in Resident #10's wheelchair to prevent a fall on 2/6/19. | F 689 | 1. Dycem was put in place for resident #10 as ordered by physician.<br><br>2. All residents with physician orders for Dycem have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on ensuring Dycem is in place as ordered by physician. Newly hired employees will receive | 6/7/19 |

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| F 689 | Continued From page 16<br>The findings include:<br><br>Resident #10 was admitted to the facility on 8/24/18 with the diagnoses of, but not limited to, depression, irritable bowel syndrome, and chronic kidney disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/22/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living and was coded as incontinent of bowel and bladder.<br><br>A review of the physician's orders revealed one dated 1/7/19 for "Dycem to w/c (wheelchair) dx (diagnosis): fall prevention."<br><br>A review of the comprehensive care plan revealed one dated 9/3/18 for falls, which included the intervention, "Dycem in w/c." This intervention was dated 1/17/19.<br><br>A nurse's note dated 2/6/19 at 10:05am, written by RN #1 (Registered Nurse) which documented the following: "Resident was noted on the floor in front of her wheelchair apparently slid from the wheelchair, no injuries visible....Resident has dementia with confusion and is unable to say what she was attempting at the time of her fall. Resident was assisted off the floor by staff x 2 with gait belts. RP (Responsible Party) and MD (Medical Doctor) are aware. Immediate Intervention: Resident was brought to the nurses station for supervision....Resident has full range of motion to all extremities. Neurological checks are within normal limits. Resident has no c/o (complaints of) pain. Pain level is 0 out of 10. Resident skin tone normal. Skin is warm and | F 689 | education on ensuring Dycem is in place as ordered by physician during facility orientation program.<br>Director of Nursing or designee will complete 100% device audit to ensure safety interventions are in place as ordered.<br><br>4. Unit Manager or designee will audit 10 residents with Dycem orders weekly to ensure it is in place as ordered by physician for 12 weeks.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| F 689 | Continued From page 17 | F 689 | | |

dry....no visible injury...."

Further review revealed another nurse's note dated 2/6/19 at 11:43am, also written by RN #1, which documented, "Resident was noted on the floor in front of her chair apparently slid from her wheelchair. Resident had dementia with confusion and impulsiveness. She is unable to state what she was attempting at the time of her fall. ROM (range of motion) is within limits VSS (vital signs stable). Resident was placed back into her wheelchair by staff assistance x 2 with gait belts. No visible injury noted. RP and MD are aware."

A review of the facility incident report for the above fall on 2/6/19 documented, "Resident was noted on the floor in her room apparently slid from her wheel chair. Resident does not know what she was attempting to do dycem {sic} was not noted to her wheelchair."

On 5/16/19 at 12:00 p.m., in an interview with RN (registered nurse) #1. When asked about the physician ordered intervention of Dycem in the wheelchair to prevent falls not being in place at the time of this fall, RN #1 stated that the resident is impulsive and picks at things and might have removed it before she was transferred to her chair. When asked if staff should be checking for the placement of the Dycem before transferring the resident to the wheelchair, RN #1 stated, "We don't check with every transfer." When asked about the process staff are to follow for checking for the Dycem, RN #1 stated, "I believe the expectation is to check when we clean the chairs every week." When asked if it is an expectation to ensure a physician ordered device for the prevention of a fall is in place prior to transferring

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| F 689 | Continued From page 18<br>the resident, RN #1 stated, "It isn't ordered to be checked with every transfer." When asked if the care plan was followed regarding the use of the Dycem, RN #1 stated, "I can't say that it wasn't followed."<br><br>On 5/16/19 at 12:14pm in an interview with ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing), ASM #2 stated that the placement of the Dycem should be checked with each transfer. When asked if the physician's order for the use of Dycem to prevent falls was followed, ASM #2 stated it was not. When asked if the care plan intervention for the use of the Dycem to prevent falls was followed, ASM #2 stated it was not.<br><br>A review of the facility policy, "Care Plan" documented, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."<br><br>No further information was provided by the end of the survey.<br><br>1. Dycem is a polymer with very high grip properties...that can be used on seats to help prevent the patient sliding off seats which can result in injury or fractured hips. | F 689 | | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater; | F 759 | | 6/7/19 |

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| F 759 | Continued From page 19<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure that three of five residents in the medication administration observation (Residents #11, #64 and #9) were free of a medication error rate of five percent or less. There were three (3) errors out of 27 opportunities and the medication error rate was 11.11%.<br><br>1. LPN (Licensed practical nurse) #1 failed to solely administer the physician prescribed 100 mg (milligrams) of Colace to Resident #11. Instead, LPN #1 administered two tablets of Colace with Senna 50 mg/8.6 mg.<br><br>2. LPN (Licensed practical nurse) #1 failed to solely administer the physician prescribed 100 mg (milligrams) of Colace to Resident #64. Instead, LPN #1 administered two tablets of Colace with Senna 50 mg/8.6 mg.<br><br>3. LPN (Licensed practical nurse) #2 failed to administer the correct physician prescribed dose of Vitamin D to Resident #9 on 5/15/19.<br><br>The findings include:<br><br>1. LPN (Licensed practical nurse) #1 failed to solely administer the physician prescribed 100 mg (milligrams) of Colace (1) to Resident #11 on 5/15/19. Instead, LPN #1 administered two tablets of Colace with Senna (2) 50 mg/8.6 mg.<br><br>Resident #11 was admitted to the facility on 7/14/17. Resident #11's diagnoses included but were not limited to high blood pressure, anxiety | F 759 | 1. Physician & resident responsible party were notified of the medication error for residents #11, #64, and #9.<br>No negative outcomes resulted in identified medication error for resident #11, #64, and #9.<br>LPN #1 and LPN #2 were educated on proper medication administration.<br><br>2. All residents who receive medications have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on proper medication administration.<br>Newly hired employees will receive education on proper medication administration during facility orientation program.<br><br>4. Unit Manager or designee will audit three nursing staff while completing medication administrations each week to ensure proper administration for 12 weeks.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| F 759 | Continued From page 20 | F 759 | | |

disorder and chronic pain syndrome. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/27/19, coded the resident's cognition as severely impaired.

On 5/15/19 at 8:25 a.m., LPN #1 was observed preparing and administering medications to Resident #11. LPN #1 prepared and administered to Resident #11 two tablets of Colace with Senna 50 mg/8.6 mg.

Review of Resident #11's clinical record revealed a physician's order dated 7/14/17 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of physician's orders failed to reveal an order for Senna. Review of Resident #11's May 2019 MAR (medication administration record) revealed a physician's order dated 7/14/17 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of the MAR failed to reveal an order for Senna.

On 5/15/19 at 12:41 p.m., an interview was conducted with LPN #1. LPN #1 was asked about the facility process for ensuring the correct medication is administered. LPN #1 stated, "You compare the medication to the MAR, make sure it's the correct patient, make sure it's the correct dose." LPN #1 was made aware Resident #11 had a physician order for 100 mg of Colace but she was observed preparing and administering two tablets of Colace with Senna to the resident. LPN #1 confirmed she should not have administered the Colace with Senna. When asked what medication should have been administered, LPN #1 stated she should have administered 100 mg of Colace without Senna.

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Resident #11's comprehensive care plan dated 6/28/18 documented, "At risk for constipation/dehydration r/t (related to) decreased mobility, weakness...Interventions: meds as ordered..."

On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" documented, "4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..."

No further information was presented prior to exit.

(1) Colace is a stool softener used to relieve constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601113.html

(2) Colace with Senna is a combination medication containing Colace (a stool softener) and Senna (a laxative) and is used to treat constipation. This information was obtained from the websites: https://medlineplus.gov/druginfo/meds/a601113.html and https://medlineplus.gov/druginfo/meds/a6011122.html

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2. LPN (Licensed practical nurse) #1 failed to solely administer the physician prescribed 100 mg (milligrams) of Colace (1) to Resident #64. Instead, LPN #1 administered two tablets of Colace with Senna (2) 50 mg/8.6 mg.

Resident #64 was admitted to the facility on 5/4/10. Resident #64's diagnoses included but were not limited to muscle weakness, difficulty swallowing and anxiety disorder. Resident #64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/1/19, coded the resident's cognition as moderately impaired.

On 5/15/19 at 8:17 a.m., LPN #1 was observed preparing and administering medications to Resident #64. LPN #1 prepared and administered to Resident #64, two tablets of Colace with Senna 50 mg/8.6 mg.

Review of Resident #64's clinical record revealed a physician's order dated 4/3/19 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of physician's orders failed to reveal an order for Senna. Review of Resident #64's May 2019 MAR (medication administration record) revealed a physician's order dated 4/3/19 for Colace 100 mg- one cap by mouth twice daily for constipation. Further review of the MAR failed to reveal an order for Senna.

On 5/15/19 at 12:41 p.m., an interview was conducted with LPN #1. LPN #1 was asked about the facility process for ensuring the correct medication is administered. LPN #1 stated, "You compare the medication to the MAR, make sure it's the correct patient, make sure it's the correct

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dose." LPN #1 was made aware Resident #64 had a physician order for 100 mg of Colace but she was observed preparing and administering two tablets of Colace with Senna to the resident. LPN #1 confirmed she should not have administered the Colace with Senna. When asked what medication should have been administered, LPN #1 stated she should have administered 100 mg of Colace without Senna.

Resident #64's comprehensive care plan dated 4/15/19 documented, "At risk for constipation/dehydration r/t (related to) decreased mobility, weakness...Interventions: meds as ordered..."

On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

(1) Colace is a stool softener used to relieve constipation. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601113.html

(2) Colace with Senna is a combination medication containing Colace (a stool softener) and Senna (a laxative) and is used to treat constipation. This information was obtained from the websites: https://medlineplus.gov/druginfo/meds/a601113.html and https://medlineplus.gov/druginfo/meds/a6011122.html

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3. LPN (Licensed practical nurse) #2 failed to administer the correct physician prescribed dose of Vitamin D (1) to Resident #9 on 5/15/19.

Resident #9 was admitted to the facility on 2/12/19. Resident #9's diagnoses included but were not limited to pneumonia, heart failure and high blood pressure. Resident #9's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 2/26/19, coded the resident as being cognitively intact.

On 5/15/19 at 8:38 a.m., LPN #2 was observed preparing and administering Resident #9's medications. LPN #2 prepared and administered one tablet of Vitamin D 400 units to Resident #9.

Review of Resident #9's clinical record revealed a physician's order dated 2/12/19 for Vitamin D3 1,000 units- one tablet by mouth every day. Review of Resident #9's May 2019 MAR (medication administration record) revealed a physician's order dated 2/12/19 for Vitamin D3 1,000 units- one tablet by mouth every day.

On 5/15/19 at 12:49 p.m., an interview was conducted with LPN #2. LPN #2 was asked about the facility process for ensuring the correct medication is administered. LPN #2 stated, "Look at the orders, doctor's orders and compare the doctor's orders with the medication." LPN #2 was made aware Resident #9 had a physician's order for 1,000 units of Vitamin D but she was observed preparing and administering 400 units of Vitamin D to the resident. LPN #2 obtained and reviewed a bottle of Vitamin D 1,000 units and a bottle of Vitamin D 400 units. LPN #2

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| F 759 | Continued From page 25<br>confirmed she administered 400 units when she should have administered 1,000 units.<br><br>Resident #9's comprehensive care plan dated 2/13/19 failed to document specific information regarding Vitamin D administration.<br><br>On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.<br><br>No further information was presented prior to exit.<br><br>(1) "Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+d&_ga=2.149763826.57397498.1558355764-1667741437.1550160688 | F 759 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly | F 812 | | 6/7/19 |

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| F 812 | Continued From page 26<br>from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner.<br><br>The facility staff failed to prepare and serve food in a sanitary manner during the tray line observation on 5/15/19. The facility staff were observed touching multiple items while wearing gloves, then without changing gloves handled food items served to residents.<br><br>The findings include:<br><br>On 5/15/19 at 11:42 AM, an observation was made of the lunch meal tray-line service in the kitchen. OSM (Other staff member) #11, a cook, was preparing each meal tray with the assistance of OSM #9, another cook. Both staff were observed with gloves on. OSM #11 was observed handling plates, serving spoon handles, tongs, and other items potentially contaminating her gloves. As OSM #11 prepared each tray, she lifted the plates from the plate warmer. OSM #11 was then observed handling buns with the same | F 812 | 1. OSM #2, OSM #9, and OSM #11 were educated on proper glove use.<br>No negative outcomes resulted in identified deficient practice.<br>OSM #2 received 1:1 education and counseling for failure to supervise the dietary staff's appropriate use of gloves during meal service.<br><br>2. All residents who receive food from the kitchen have the potential to be effected by the deficient practice.<br><br>3. District Dietician or designee will educate dietary staff on proper use of gloves to ensure food is prepared and served in a sanitary manner.<br>Newly hired dietary employees will receive education on proper glove use during facility orientation program.<br><br>4. Administrator or designee will audit 5 meal services weekly to ensure proper glove use for 12 weeks.<br>Audit results will be presented monthly for | |

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| F 812 | Continued From page 27<br>gloved hands after handling the plates and service spoons without changing her gloves. OSM #11 was observed putting the bags of buns directly on top of the opened cheese slices after the first round of tray-line service was completed.<br><br>Throughout tray-line, OSM #9 was observed setting up the plates for OSM #11 with buns, lettuce, tomato slices, pickles, and cheese. OSM #9 was observed touching tongs, plates, bowls, and plastic bags of buns with the same gloves on potentially contaminating them. OSM #9 was observed removing buns from the bags and placing them on the plates, then removed sliced cheese with her gloved hands and placed the cheese on the buns, all with the same gloves on.<br><br>On 5/15/19 at 12:36 PM, tray-line service was then switched from preparing trays for the units to preparing trays for the dining room. OSM #11 was preparing each meal tray with the assistance of OSM #9. OSM #11 was observed opening a bag of plastic rectangle Styrofoam divided plates for serving residents "cook out" style per the special event in the facility for the day. She removed the plastic plates from the bag and placed them on the plate warmer with her gloved hands. Throughout tray-line, OSM #9 was observed setting up the Styrofoam plates for OSM #11 with buns, lettuce, tomato slices, pickles, and cheese. OSM #9 was observed touching tongs, Styrofoam plates, bowls, and plastic bags of buns with the same gloves on. OSM #9 was observed removing buns from the bags and placing them on the Styrofoam plates, then removed sliced cheese with her gloved hands and placed the cheese on the buns, all with with the same gloves on. | F 812 | three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| F 812 | Continued From page 28<br>On 5/15/19 at 1:40 PM, an interview was conducted with OSM #2, the Dietary Service Manager. When OSM #2 was asked if staff should handle food with gloved hands, if they had touched multiple potentially contaminated items with those gloves, OSM #2 she stated, "No. It shouldn't be that way."<br><br>A review of the facility's policy "Food Preparation and Handling" with a revision date of February 20, 2019 that documented in part, "Policy: Food items are prepared by methods designed to ...avoid cross-contamination, prevent food borne illness ...Equipment ...Silverware is stored in such a manner as to encourage contact with handles only ...Handle utensils, cups, glasses, and dishes in such a way as to avoid touching the surfaces that food or drink will come in contact with. Use tongs, or other serving utensils to serve breads or other items. Never touch food directly with bare hands ..."<br><br>On 5/15/19 at 1:50 PM, ASM (Administrative Staff Member) #1, the Administrator was made aware of the findings.<br><br>No further information was provided by the end of the survey. | F 812 | | |
| F 814 SS=C | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain the dumpster area | F 814 | 1. Debris identified upon inspection were collected and dumpster area was cleaned. OSM #3 received 1:1 education and | 6/7/19 |

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| F 814 | Continued From page 29<br>in a clean and sanitary manner to prevent pests.<br><br>On 5/14/19, a pile of debris was observed on the ground approximately a foot from the dumpster. The pile contained two used non-latex gloves, paper and plastic medicine cups, bottle caps, plastic spoon, straws, food foil wrapper, aluminum drink can, and a Styrofoam bowl.<br><br>The findings include:<br><br>On 5/14/19 at 12:39 PM, an inspection of the facility dumpster area was conducted with OSM (Other Staff Member) #2, the Dietary Service Manager. A pile of debris was observed on the ground approximately a foot from the dumpster. The pile contained two used non-latex gloves, paper and plastic medicine cups, bottle caps, plastic spoon, straws, food foil wrapper, aluminum drink can, and a Styrofoam bowl.<br><br>On 5/14/19 at 12:41 PM, an interview with OSM #2 was conducted. When OSM #2 was asked if the pile should be on the ground, she stated, "No. But everyone uses it. I will get someone to clean it." When OSM #2 was asked who is responsible for keeping the dumpster area clean, she stated, "I don't want to say. It is maintenance but it should be everyone's job." When OSM #2 was asked if maintenance is responsible, she stated "Yes."<br><br>On 5/14/19 at 2:05 PM, an interview was conducted with OSM #3, the Maintenance Director. When OSM #3 was asked who is responsible for the upkeep of the dumpster, he stated, "Me and another guy, we usually clean the area on Monday, Wednesday, and Friday. The trash is dumped every day. Normally I try to | F 814 | counseling for failure to ensure dumpster area was maintained in a clean and sanitary manner as directed.<br><br>2. All residents have the potential to be effected by the deficient practice.<br><br>3. Administrator will educate maintenance staff on ensuring dumpster area is maintained in a clean and sanitary manner daily.<br>Newly hired maintenance employees will receive education on proper dumpster area maintenance during facility orientation program.<br><br>4. Administrator or designee will audit dumpster area 5 times a week to ensure proper maintenance for 12 weeks.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| F 814 | Continued From page 30<br>clean it every morning. It might be that I just hadn't gotten out here. We generally try to keep it looking good."<br><br>A review of the facility's policy "Waste Disposal" with a revised date of June 5, 2018 that documented in part, "Policy: Trash and garbage will be disposed of as needed throughout the day and at the end of each day. Procedure ...Trash will be deposited into a sealed container outside the premises ..." The policy did not address the area surrounding the dumpster.<br><br>On 5/15/19 at 1:50 PM, ASM (Administrative Staff Member) #1, the Administrator was made aware of the findings.<br><br>No further information was provided by the end of the survey. | F 814 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete; | F 842 | | 6/7/19 |

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(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 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;

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| F 842 | Continued From page 32<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical review and review of facility documentation, it was determined that the facility staff failed to maintain an accurate clinical record for two of 37 residents in the survey sample, Residents #44 and #417.<br><br>1. The facility staff failed to document Resident #44's medication after it was administered on 5/12/19.<br><br>2. The facility staff failed to document Resident #417's treatment after it was administered on 5/9/19.<br><br>The findings include:<br><br>1. The facility staff failed to document Resident #44's physician ordered medication after it was administered.<br><br>Resident #44 was admitted to the facility on 2/16/18. Resident #44's diagnoses included but were not limited to: heart failure, respiratory failure and muscle weakness. Resident #44's most recent MDS (minimal data set), a quarterly assessment with an ARD (assessment reference date) of 4/17/19, coded the resident's cognition as cognitively intact. | F 842 | 1. Physician and resident responsible party were notified of facility's failure to maintain an accurate clinical record for resident #44 and #417.<br>No negative outcomes resulted in identified deficient practice.<br>LPN #2 was educated on signing resident MAR/TAR after administering medications.<br><br>2. All residents who receive medications have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on proper medication administration documentation.<br>Newly hired employees will receive education on proper medication administration documentation during facility orientation program.<br>Director of Nursing or designee will complete a 7 day look-back at resident MAR/TAR of admitted residents to ensure proper medication administration documentation.<br><br>4. Unit Manager or designee will audit 10 | |

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| F 842 | Continued From page 33<br><br>Review of Resident #44's clinical record revealed a physician order dated 2/27/18 that documented, "Bumex (1) 0.5 mg tablet - take 1 tablet by mouth every day for heart failure."<br><br>Review of Resident #44's May 2019 MAR (medication administration record) revealed Bumex was not documented as administered on 5/12/19.<br><br>On 5/16/19 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked about the process staff follows for documenting in the resident's clinical record. LPN #2 stated, "You document after you have finished administering medications, treatments or if there is some type of change in condition so other clinical staff will know the status of the resident." LPN #2 was asked if she administered Resident #44's Bumex on 5/12/19 at 9:00 a.m. LPN #2 stated, "Yes but, I forgot to sign on the MAR (medication administration record)."<br><br>The facility policy titled, "Physician Orders Documentation", did not document any information regarding documentation on the (MAR) medication administration record.<br><br>On 5/16/19 at 10 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern.<br><br>No information was presented prior to exit.<br><br>2. The facility staff failed to document Resident #417's treatment after it was administered on 5/9/19. | F 842 | resident's MAR/TAR weekly for 12 weeks to ensure nursing staff are following proper medication administration documentation.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TYLER'S RETREAT AT IRON BRIDGE | 12001 IRON BRIDGE RD CHESTER, VA 23831 |

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Resident #417 was admitted to the facility on 5/6/19. Resident #417's diagnoses included but were not limited to: seizure disorder, hyperlipidemia and Parkinson's disease. An MDS (minimal data set) had not been completed yet for Resident #417. Resident 417's cognition was documented as, "Sometimes understood" per the 5/6/19 admission assessment.

Review of Resident #417's clinical record revealed a physician order dated 5/6/19 that documented, "Nystatin powder (2) 10000 units per gram, apply to right breast two times a day for ten days."

Review of Resident #417's May 2019 treatment administration record revealed Nystatin had not been documented as being administered on 5/9/19.

On 5/16/19 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked what the process is for documenting in the resident's clinical record. LPN #2 stated, "You document after you have finished administering medications, treatments or if there is some type of change in condition so other clinical staff will know the status of the resident." LPN #2 was asked if she administer Resident #417's treatment order. LPN #2 stated, "Yes but, I forgot to sign on the TAR (treatment administration record)."

The facility policy titled, "Physician Orders Documentation", did not document any information regarding documentation on the (TAR) treatment administration record.

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| F 842 | Continued From page 35<br>On 5/16/19 at 10 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern.<br><br>No information was presented prior to exit.<br><br>(1) Bumex - a medication used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684051.html<br><br>(2) Nystatin - a medication used to treat fungal infections of the skin. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual | F 880 | | 6/7/19 |

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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 corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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| F 880 | Continued From page 37<br>transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to implement infection control practices for one of 37 residents in the survey sample, Resident #9.<br><br>LPN (Licensed practical nurse) #2 failed to handle Resident #9's medication cup containing pills in a clean and sanitary manner to prevent the spread of infection and communicable diseases.<br><br>The findings include:<br><br>Resident #9 was admitted to the facility on 2/12/19. Resident #9's diagnoses included but were not limited to pneumonia, heart failure and high blood pressure. Resident #9's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 2/26/19, coded the resident as being cognitively intact. Resident #9's comprehensive care plan dated 2/13/19 failed to document specific information regarding the handling of medication cups.<br><br>On 5/15/19 at 8:38 a.m., LPN #2 was observed preparing and administering Resident #9's medications. While preparing the medications, LPN #2 touched the handle of the medication cart with her left hand while opening a drawer then immediately placed her left index finger inside of | F 880 | 1. No residents were found to be effected by identified deficient practice.<br>LPN #2 was educated on handling resident medication cup in a clean and sanitary manner.<br><br>2. All residents who receive medications have the potential to be effected by the deficient practice.<br><br>3. Director of Nursing or designee will educate nursing staff on handling resident medication cups in a clean and sanitary manner.<br>Newly hired employees will receive education on handling resident medication cups in a clean and sanitary manner during facility orientation program.<br><br>4. Unit Manager or designee will audit medication administration 3 times weekly to ensure proper handling of resident medication cups for 12 weeks.<br>Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. | |

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the medication cup containing pills while picking the cup up. That medication cup containing pills was administered to Resident #9.

On 5/15/19 at 8:56 a.m., an interview was conducted with LPN #2. LPN #2 was asked how she should handle a medication cup containing pills. LPN #2 stated, "You hold it at the bottom, not at the tip." LPN #2 described the "tip" as the top rim of the medication cup. When asked why, LPN #2 stated, "So you don't contaminate the top part." When LPN #2 was made aware of the above observation LPN #2 stated she did not know that she had placed her finger inside of the medication cup.

On 5/15/19 at 5:41 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" failed to document specific information regarding the handling of medication cups.

No further information was presented prior to exit.