

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(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 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from March 16, 2016 through March 28, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 112. The Stage 2 sample totaled 32 (thirty two) residents.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set- standardized assessment form used in nursing homes; NP - Nurse Practitioner; Physician Order Sheet (POS) - monthly report of active physician orders; RNAC - Registered Nurse Assessment Coordinator; ABHR-topical medication containing an antipsychotic medication; Acetaminophen (Tylenol) - medication for pain or fever; AIMS-abnormal involuntary movement scale-test designed to measure involuntary movements; Albuterol - inhaled medication to treat shortness of breath; Anxiety- worried, nervous or restless feelings; Apical pulse -counting heart rate by listening to the chest with a stethoscope; BIMS (Brief Interview for Mental Status) - test to</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ann Amburn* TITLE *Administrator* (X8) DATE *5/23/16*

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

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F 000	Continued From page 1 measure thinking ability[cognltion] with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment BM - bowel movement; BP (blood pressure) - the measure of the force of the blood against the walls of a blood vessel; Congestive Heart Failure (CHF) - heart cannot pump enough blood to meet the body's needs; Clotrimazole - cream used for a rash; Cognition - mental processes or thinking; Colace - stool softener; Constipation - difficulty in passing stool; Diarrhea - liquid or semi-liquid stool; Diabetic/Peripheral Neuropathy -nerve disease causing numbness and pain in the hands/feet; Diastolic BP - bottom number in the BP reading; Digoxln - medication to treat heart conditions; Digoxin level - blood test to see if resident is getting enough (not too much); Duoneb - inhaled medication to treat shortness of breath; EMR-electronic medical record; Extensive Assistance - resident involved in activity, staff provide weight-bearing support; Fahrenheit (F) - temperature scale; Heparin lock flush - medication injected to prevent a catheter in the vein from clotting; Hydralazine - medication for blood pressure; Hyperlipidemia - high levels of cholesterol and triglycerides in the blood; Ibuprofen - medication for pain, inflammation or fever; Insulin - Injected medication to control blood sugar levels; Intravenous catheter - small tube in the vein to give medication; Lasix - diuretic medication to reduce	F 000		
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F 000	Continued From page 2 water/excess fluid in the body; Levimir-long acting insulin; Lantus-long acting insulin; Laxative - medication to promote bowel movement; Lupus - disease where the immune system is overactive; MAR-medication administration record; Milligram (mg) - metric unit of weight, mass; Mucinex - medication for cough and congestion; Nebulizer Treatment- inhaling medication mist directly into lungs; Novolog-rapid acting insulin; Oxycodone - narcotic pain medication; POS-physician order sheet; PRN-as needed; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Passive Range of Motion (PROM) - extent to which a joint can be moved safely with/by staff; Pneumonia - lung infection; Prednisone - steroid medication to reduce inflammation; Preparation H suppository - medication given rectally for burning and itching; Restasis-medicated eye drops; Respiratory Failure - inadequate breathing; Stenosis - narrowing of a passage; Supervision - oversight, encouragement or cueing; Systolic BP - top number of the BP reading; Total Dependence - full staff performance every time activity performed; Tramadol - pain medication; UTI - urinary tract infection; Vital signs - clinical measurements (that is pulse rate, temperature, respiration rate, blood pressure);	F 000			

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F 000 F 241 SS=E	Continued From page 3 Xanax - medication to treat anxiety. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on multiple observations, it was determined that the facility failed to promote care in a manner that promotes or enhances dignity by entering random resident rooms 22 times without permission, obtaining diet order by talking loudly from the doorway 5 times and, for R198, placing a clothing protector without asking permission. Findings include: 1. On 03/16/2016 at 8:30 AM, during the initial tour, E16 (CNA) entered resident room 210 without knocking or asking for permission to enter. 2. On 03/16/2016 between 12:00 PM and 12:50 PM, the following random observations were made while staff were serving lunch on Unit 2: -12:20 PM, E17 (CNA) entered resident room 223 without knocking or asking for permission to enter; -12:21 PM, E17 stood in the hall in front of resident room 225 without knocking or addressing the resident by name and said to resident: "do you want egg salad sandwich?" -12:25 PM, E17 entered resident room 227 without knocking or asking for permission to	F 000 F 241	F241 A. Staff entered resident's rooms 210, 223, 227, 229, 211, 215, 217, 230, 205, 206, 208, 221, 225, and 229 without knocking and/or asking permission to enter. B. NHA, DON, or designee will complete random rounds to ensure that resident dignity and respect are maintained. C. Nurse Practice Educator will educate current staff on Genesis HealthCare Operations Policy and Procedure OPS 213 Treatment: Considerate and Respectful. (Attachment C). D. The Nurse Practice Educator will monitor 10 random employee resident encounters on each nursing unit to determine resident's dignity is respected. (Attachment D). The audit will be performed daily until 100% success is achieved for 3 consecutive days, then 3 times a week until 100% success is achieved for 3 consecutive audits, then once a week until 100% success for 3 consecutive audits. The audit will be conducted one month later and if 100% success is reached, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.	5/16/2016

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F 241	<p>Continued From page 4</p> <p>enter; -12:26 PM, E18 (CNA) entered resident room 229 without knocking or asking for permission to enter; -12:27 PM, E17 stood in the hall in front of resident room 240 without knocking or addressing the resident by name and said to the resident: "what would you like to eat?" -12:31 PM, E16 (CNA) entered resident room 210 while saying the words "knock knock", but did not ask for permission to enter; -12:33 PM, E16 (CNA) entered resident room 211 while saying the words "knock knock", but did not ask for permission to enter; -12:40 PM, E8 (CNA) entered resident room 216. She knocked and entered without asking for permission to enter; -12:40 PM, E16 entered resident room 217 without knocking or asking for permission to enter.</p> <p>3. On 03/16/2016 at 01:26 PM, during a stage 1 interview with SS5 in her room with the door closed, E19 (CNA) opened the door and walked into the resident's room without knocking or asking for permission to enter. When E19 saw the surveyor, E19 stopped and said "I wanted to check what was going on in here because the door was shut." and left the room.</p> <p>4. On 03/18/2016 at 09:30 AM, during a stage 1 interview with R148 in his room, E22 (CNA) walked into the resident's room without knocking or asking for permission to enter.</p> <p>5. On 03/22/2016 between 12:00 PM and 12:55 PM, the following random observations were made while staff were serving lunch on Nursing Unit 2:</p>	F 241	<p>F241</p> <p>A. Staff obtained diet order from the resident by talking loudly from the doorway in front of rooms 225, 240, 236, and 227. Staff was educated and rounds were conducted by NHA/DON to monitor obtaining permission to enter resident rooms to ask meal preference.</p> <p>B. NHA, DON, or designee will complete random rounds to ensure resident dignity and respect is maintained.</p> <p>C. Nurse Practice Educator will educate current staff on Genesis HealthCare Operations Policy and Procedure OPS 213 Treatment: Considerate and Respectful. (Attachment C).</p> <p>D. The Nurse Practice Educator will monitor 10 random employee resident encounters on each nursing unit to determine resident's dignity is respected. (Attachment D). The audit will be performed daily until 100% success is achieved for 3 consecutive days, then 3 times a week until 100% success is achieved for 3 consecutive audits, then once a week until 100% success for 3 consecutive audits. The audit will be</p>	5/16/2016

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F 241	Continued From page 5 -12:13 PM, E19 (CNA) entered resident room 230. She knocked and entered without asking for permission to enter. -12:22 PM, E16 entered resident room 205 while saying the words "knock knock", but did not ask for permission to enter. -12:23 PM, E16 entered resident room 206 while saying the words "knock knock", but did not ask for permission to enter. -12:25 PM, E16 entered resident room 208 while saying the words "knock knock you want chicken or egg salad ", but did not knock or ask for permission to enter. -12:26 PM, E16 entered resident room 210 while saying the words "knock knock" and carrying a drink and cookie, but but did not knock or ask for permission to enter. -12:27 PM, E25 (CNA) entered resident room 211 without knocking or asking for permission to enter. -12:35 PM, E18 entered resident room 221 without knocking or asking for permission to enter. -12:36 PM, E20 (CNA) knocked on door of resident room 236 and while standing in hall said to resident "you want a cookie?" -12:37 PM, E18 entered resident room 225 while saying "you want egg salad or chicken?", but did not knock or ask for permission to enter. -12:40 PM, E20, while standing in the hall outside of room 227 asked "[resident's first name] what you want?" -12:43 PM, E19, while standing in hall outside of room 240 asked "what you want?" -12:45 PM, E18 entered resident room 221 without knocking or asking for permission to enter. -12:46 PM, both E18 and E20 entered resident room 229 without knocking or asking for	F 241	F241 conducted one month later and if 100% success is reached, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations. F241 A. Staff placed a clothing protector on R198 without asking permission of this resident who is alert and able to respond to questions. Staff was educated and rounds were conducted by NHA/DON to monitor obtaining permission to place clothing protectors on residents. B. NHA, DON, or designee will complete random rounds to ensure resident dignity and respect is maintained. C. Nurse Practice Educator will educate current staff on Genesis HealthCare Operations Policy and Procedure OPS 213 Treatment: Considerate and Respectful. (Attachment C).		

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F 241	Continued From page 6 permission to enter. 6. On 03/22/2016 at 12:50 PM, E19 (CNA) was observed placing a white terry clothing protector around R198's neck, without asking permission from this alert resident who was able to respond appropriately to simple questions. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/28/16 at 2:20 PM.	F 241	D. The Nurse Practice Educator will monitor 10 random employee resident encounters on each nursing unit to determine resident's dignity is respected. (Attachment D). The audit will be performed daily until 100% success is achieved for 3 consecutive days, then 3 times a week until 100% success is achieved for 3 consecutive audits, then once a week until 100% success for 3 consecutive audits. The audit will be conducted one month later and if 100% success is reached, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.	5/16/2016	
F 244 SS=B	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interviews, it was determined that the facility failed to act upon 2 grievances of the resident council group affecting linens and assistance in the dining room. These concerns related to the Resident Council Meeting minutes were found. Findings include: On 3/22/16 at 9:30 AM, during an interview with R100 (Resident Council President for the past several years), R100 informed the surveyor of unresolved grievances in the area of linen and dining room assistance, as well as concerns related to the meeting minutes:	F 244	F244 A. Current residents were not being provided a fresh towel and wash cloth each morning and as needed according to Resident Council. B. Current residents will be provided a fresh towel and wash cloth each morning and as needed. This will be provided by the 11-7 nursing staff during their shift.		

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F 244	Continued From page 7 1. Linens: R100 stated there has been an "ongoing battle between residents and staff for several years about residents getting clean towels and wash cloths." R100 said that residents want a clean towel and wash cloth every morning but many days that does not happen, as recently as 3/20/16. R100 stated the facility said residents were hoarding linens, but she knows of only two residents who hoard linens. R100 added that residents who cannot go and get their own linen are often not getting clean linen when they ask. Review of resident council meeting minutes from September, 2015 through March, 2016 revealed: - 9/11/15: old business stated "shortage of linen is an ongoing issue." Solution by E1 (NHA) was "We are still finding linen in resident rooms." - 10/14/15: old business stated "residents discussed the towel and wash cloth shortage." E1's solution was that E1 would "speak with housekeeping staff." - 11/6/15: there was no evidence of follow-up on the linen issue and minutes did not say it was resolved. - 12/4/15: Residents would like to have "one towel and one wash cloth in the morning for each person." E1's solution included that E1 would "in-service staff again, but if they [resident] should need one please ask the aide or nurse." - 1/15/16: "When staff take out a dirty wash cloth or towel, can they replace them at that time and not wait until the next day." E1 wrote under solution that she "in-serviced about the towels and wash cloths so from this point on I [E1] need to know who is not getting theirs so I can go to that particular aide." - 2/5/16: there was no evidence of follow-up on this linen issue and minutes did not reflect	F 244	F244 C. Nurse Practice Educator will educate Environmental and nursing staff on the process for distributing linen including a towel and washcloth will be given to Nursing Assistants for each resident at the beginning of the 7-3 shift (Attachment E). D. The Unit Manager will Monitor 10 random residents to determine compliance with linen distribution. (Attachment H). Random Audits will be performed on 10 residents on each nursing unit daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive audits, then once a week until 100% success for 3 consecutive audits. The audit will be conducted one month later and if 100% success is reached, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee. F244 A. The RNAC provided a list of all residents that require assistance in the dining room during mealtimes. CNA's provide all residents on this list with assistance during mealtimes. B. The RNAC review the most recent MDS of each resident and to determine those residents who require assistance with meal set up.	5/16/2016	

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F 244	<p>Continued From page 8 resolution.</p> <p>- 3/4/16: "Still an ongoing issue with towels and wash cloths even though they are ordered each month." E1's solution stated "Yes, I order every month. I will ask nursing to in-service CNA's not to hide linens in resident rooms."</p> <p>Review of in-service documentation conducted 1/7/16 found that 37 staff members were informed that "Each resident should have a new towel and wash cloth placed in the bathroom every day. This should be done when the clean linen arrives."</p> <p>During an interview with E1 and E2 (DON) on 3/28/15 at 10:30 AM, E1 provided a current inventory of wash cloths and towels (on Unit 1, Unit 2, in the laundry in Salisbury and on reserve) as well as purchase orders for wash cloths and towels purchased monthly by the facility during the past 7 months. However, E1 and E2 did not show how having the inventory ensured that residents received clean linen daily.</p> <p>2. Residents needing assistance to cut up food in the dining room.</p> <p>R100 stated "CNAs need to help residents cut up food in the dining room" and added that staff should look for residents that are "just moving their fork around in the food" and not eating because they need help to cut their food. R100 added that other residents eating in the dining room "are aware who needed help" and wondered why they were not being assisted. R100 gave several examples: - When R43 [has right sided weakness and minimal motion of that hand] asked a CNA for</p>	F 244	<p>F244</p> <p>C. A list of residents requiring assistance with meal set-up will be developed and placed in the dining room in a HIPAA secure location (Attachment F).</p> <p>D. The RNAC or designee will monitor breakfast, lunch and dinner in the dining room to determine residents are being assisted as needed with meal set-up (Attachment I). An audit will be performed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive audits, then once a week until 100% success is achieved for 3 consecutive audits. The audit will be conducted one month later and if 100% success is reached,, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee.</p> <p>F244</p> <p>A. The Resident council minutes were not accurate and not given to R100 in a timely manner.</p>	5/16/2016

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F 244	<p>Continued From page 9</p> <p>help this morning (on 3/22/16) at breakfast, the CNA responded "You cut your food yourself at dinner last night, why can't you cut your own waffles now?" R43 did not receive assistance to cut up his food.</p> <p>- SS4 has been seen trying to cut his food by using a fork to pull the food apart, but staff did not offer to help.</p> <p>- R107 will not eat a sandwich, but if the the food is taken off the bread the resident will eat. Staff do not consistently take the food off the bread.</p> <p>Review of resident council meeting minutes from September, 2015 through March, 2016 revealed:</p> <p>- 9/11/15: "not cutting up food for residents is becoming an issue again. Staff is not doing it." The minutes included the names of 9 residents who need help cutting their food up and requesting staff to "please ask them." Solution written by E1 included "I will talk to our dining room staff to make sure they understand the importance of cutting up residents' food."</p> <p>- 10/14/15: "discussed the residents that need their food cut up." E1's solution was that E1 would speak to the food service manager.</p> <p>- 11/6/15, 12/4/15, 1/15/16, 2/5/16 and 3/4/16: there was no evidence of follow-up on the dining assistance issue and minutes did not say it was resolved.</p> <p>Dining Room observation 03/22/2016 from 4:00 PM - 5:10 PM revealed:</p> <p>- 4:19 PM: SS4 walked with staff assistance to a table and was served his drink and plate of food by staff, but no one offered to help cut up the food.</p> <p>- 4:26 PM: R43 walked into dining room and E23 (Dietary Aide) helped the resident to sit and adjust his chair. R43 was served his drink and plate of</p>	F 244	<p>F244</p> <p>B. The Activities Department is responsible for the accurate transcription of the Resident Council Minutes, sign in sheet, and the timely manner of distribution of minutes for review to R100 prior to the next meeting. NHA is responsible for the timely and correct response to grievances.</p> <p>C. Nursing Home Administrator will educate staff that participate in Resident Council meetings and assigned follow up of minutes/grievances on F tag 244 and Title 42. 483.15(c) (6) requirements including, attendance sheet sign in, response to complaints, and timeliness of transcription of the minutes (Attachment G).</p> <p>D. The NHA will conduct a monthly audit of the Resident Council meeting minutes to determine attendance sheets are complete, previous complaints are resolved, and the minutes are transcribed in a timely manner (Attachment J). These audits will be ongoing until 100% success is achieved for 3 consecutive months. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.</p>	5/16/2016

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F 244	<p>Continued From page 10 food by staff, but no one offer to help cut up his food.</p> <p>During an interview with E1 on 3/24/15 at 1:40 PM about the resident council grievances, E1 said she assumed there were no longer problems because she did not hear any more complaints. The facility failed to consistently analyze grievances from previous resident council meetings resulting in the failure to determine resolution.</p> <p>3. Resident Council Meeting Minutes Review of the September 2015 to March 2016 minutes found names of residents attending each meeting were not included in minutes, only the number of residents who attended. Names of management staff who attended and how they responded to concerns were either not included or unclear in the minutes.</p> <p>E24 (Activities Director) provided the surveyor with a typed list of names of residents who attended by month. However, there was a discrepancy between the number of residents listed in the minutes when compared to the list provided by E24.</p> <p>During an interview with R100 on 3/22/16 at 9:30 AM, R100 explained that E24 writes the minutes after receiving notes from R100 and the co-secretary. R100 complained that she would not get a copy of the minutes to review until the next month's meeting. R100 added that the minutes were not always accurate and was told by E24 that "it's too late now" when wanting corrections. R100 explained since managers do not consistently respond with solutions, R100 (or</p>	F 244			

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F 244	Continued From page 11 the resident with the grievance) would address it with management themselves. During an interview with E1 on 3/24/16 at 1:40 PM E1 stated that E24 reviewed the Resident Bill of Rights every February, but this was not reflected in February 2016 minutes. E1 pointed out that the January 2016 minutes documented that the location of resident rights posters and discussion about resident rights would occur next month in February 2016. The ombudsmen's name and contact number was included in the January minutes. The facility failed to adequately act upon grievances of the Resident Council to ensure residents had a clean wash cloth and towel daily and residents' food was cut up if needed.	F 244	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview It was determined that the facility failed to provide a reasonable accommodation of individual needs	F 246	F246 A. R198 call bell was placed within reach by the nursing assistant. B. Rounds were completed by Nurse Managers on each nursing unit including bathrooms to determine call bells were within reach. Residents requesting call bell be kept on the side rail of bed were assessed to determine accessibility when out of bed and ADL care plan was revised as needed and over bed lights were accessible.

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F 246	<p>Continued From page 12</p> <p>for two (R198 and R140) out of 32 sampled residents by not having the call bell or overbed light cord within reach. Findings include:</p> <p>1. On 3/16/16 (4:15 PM) during an observation of R198:</p> <ul style="list-style-type: none"> - While at Unit 2's nursing station, the surveyor heard R198 yelling for help from her room. No staff responded. - R198's door was open and after receiving the resident's permission to enter, the surveyor saw R198 sitting alone in the room in a wheelchair. The resident said she needed assistance to get into bed. - When asked if she could ring her call bell, R198 stated, "I can not reach it." R198's call bell was observed tied around the bed's upper siderail that was pushed against the wall. R198 was unable to reach the call bell. - R198 asked the surveyor to push the call bell and a few minutes later, E13 (CNA) entered the room, confirmed the call bell was not in reach and stated the nurse was going to give the resident medications before R198 was to be assisted back into bed. <p>During an interview with E13 on 3/16/16 at 4:30 PM, E13 confirmed that no other staff were in R198's room when E13 answered the call bell. E13 further stated that E14 (nurse) was still in the room when E13 had to leave the room.</p> <p>This observation was reviewed with E4 (UM) on 3/16/16 at 4:35 PM.</p> <p>2. During an interview on 3/18/2016 (10:30 AM) R140 stated that when in bed he was not able to reach the string to activate the overbed light. The resident added that staff told him he could not tie</p>	F 246	<p>F246</p> <p>C. Nurse Practice Educator will instruct nursing staff on requirement that call bells are to be within reach of the resident before leaving the room and call bells may not be wrapped around the bed rail or chair unless resident requests, in addition this Intervention must be placed on residents ADL care plan (Attachment H).</p> <p>D. Director of Nursing or designee will monitor 10 random residents on each unit to determine call bells are within reach of resident and not wrapped around bed rail or chair without permission of resident (Attachment J). Audits will be performed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive evaluations, then once a week until 100% success is achieved for 3 consecutive evaluations, then monthly x 1, if 100% success is achieved, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and</p>		

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F 246	Continued From page 13 the string to the side rail on his bed. R140 stated he only has use of one arm and needs to have the overbed light string accessible. R140's overbed light was observed with a broken string (half tied to left siderail, the other half attached to light) preventing R140 from being able to use the light while in bed. On 3/18/16 at 12:30 PM E4 (UM) and E15 (Maintenance Director) confirmed the resident was not able to reach the string to the light. During an interview with E15 on 3/18/16 at 3:00 PM, E15 stated that he has resolved this issue for R140. These findings were reviewed with E1(NHA) and E2(DON) on 3/28/15 at 10:30 AM and at 2:20 PM.	F 246	F246 recommendations. A. R140 over bed light cord was repaired by maintenance. B. Rounds were completed by Maintenance staff on each nursing unit to determine over bed light was accessible by resident, if not the cord was repaired or replaced. C. Maintenance staff will be educated by Director of Maintenance on completing maintenance rounds including, repair of over bed light strings that are broken or unreachable by resident. (Attachment I). D. Maintenance Director or designee will audit 10 random resident rooms on each unit to determine over bed light cords are intact and reachable (Attachment K). Audit will be performed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive evaluations, then once a week until 100% success is achieved for 3 consecutive evaluations, then monthly, if 100%	5/16/16	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272			

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F 272	<p>Continued From page 14</p> <p>Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accuracy of the comprehensive assessment for one (R126) out of 32 sampled residents. Findings include:</p> <p>1. Review of R126's clinical record revealed; 2/25/16 - R126's Initial nursing assessment completed upon re-admission to the facility documented "Present" to the question of "Dentures or removable bridge". Questions on the type of dentures (full / partial, upper / lower) and whether they fit properly were not answered for this alert resident.</p>	F 272	<p>F246</p> <p>success is achieved, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.</p> <p>F272</p> <p>A. R126 MDS dated 3/23/16 was in progress during survey and was corrected 3/23/2016 to reflect correct oral status.</p> <p>B. Clinical Reimbursement Coordinator and/or designee will review MDS for residents admitted 3/1/16 to present to determine other resident that may be affected by the deficient practice.</p> <p>C. Nurse Practice Educator will educate licensed nursing staff on accuracy of initial and expanded nursing assessments including, oral assessment. (Attachment I).</p>	5/16/16

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F 272	Continued From page 15 3/3/16 MDS 5-day assessment - Oral/Dental section documented that R126 had no dental issues. 3/16/16 at 11:35 AM - During Stage 1 interview, when asked "Do you have any problems with your teeth, gums, or dentures?" R126 responded "yes" since she could not wear her bottom denture due to it rubbing on the bone. The resident stated the issue was present when she returned to the facility last month. The resident was observed to be wearing only her upper dentures. During an interview on 3/23/16 at 1:25 PM with E2 (DON) and E3 (RN, unit manager), when asked if R126 complained about bottom dentures not fitting, the answer was no. E3 stated that the resident lost weight with her several hospitalizations and they can have the dentist see her since he can sometimes adjust dentures to fit. During an interview on 3/24/16 at 10:40 AM with E2 when discussing the flow of data from computer entries into the MDS assessment, E2 stated that responses from the initial assessment flow into the MDS. The inaccurate initial assessment lead to the incorrect entry on the MDS 5-day assessment. These findings were reviewed with E1 (NHA) and E2 on 3/28/16 at 2:20 PM.	F 272	F272 D. Clinical Reimbursement Coordinator or designee will monitor newly admitted residents to determine the initial and expanded dental assessment are accurate. (Attachment M). Audits will be performed on each new admission until 100% success is achieved for 3 consecutive audits, then 3 x a week on Monday, Wednesday, Friday admissions until 100% success is achieved for 3 consecutive evaluations, then weekly on Wednesday admissions until 100% success is achieved for 3 consecutive evaluations, then monthly X 1 if 100% success is achieved, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and performance Improvement Committee for data evaluation and recommendations.	5/16/2016	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278			

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F 278	<p>Continued From page 16</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately code the functional status section of the MDS assessment for 1 (R198) of 32 sampled residents. Findings include:</p> <p>Review of the clinical record for R198 revealed; 2/10/16 30 day MDS assessment documented "locomotion on unit " as extensive assistance.</p> <p>3/9/16 60 day MDS assessment documented "locomotion on unit " as total dependence.</p>	F 278	<p>F 278</p> <p>A. R198 MDS dated 2/10/16 has been corrected to reflect resident status for the 7 day look back period.</p> <p>B. Current residents have the potential to be affected by the deficient practice. Clinical Reimbursement Coordinator or designee will review MDSs completed 4/1/16 to present to determine accuracy of resident functional status.</p> <p>C. Nurse Practice Educator will educate CNAs on accurate coding of activities of daily living including resident functional status.(Attachment Q).</p>	

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F 278	Continued From page 17 Review of the clinical record lacked consistent evidence that, during the 7 day look back review period for the 30 day MDS assessment dated 2/10/16, R198 was involved in activity for locomotion on unit. During an interview on 3/24/16 at 12:00 PM, E11 (RNAC) explained that the nursing assessment data in the EMR is populated into the MDS. If one staff member documents that R198 was involved in activity for locomotion on the unit, the MDS will select "extensive assistance". E11 admitted that she did not analyze or assess R198's automatically populated EMR data, but just submitted the 2/10/16 MDS. E11 provided the CNA documentation of "locomotion on unit" from the facility's EMR for this review period. E11 stated that one time "extensive assistance" was documented incorrectly and this was a MDS error. It should have been coded "total dependence" because there was no decline for R198. During an interview on 3/28/16 at 09:35 AM, E11 reconfirmed that this was a coding error on the MDS and that she understands the MDS assessment was inaccurate. E11 stated she will do a MDS correction.	F 278	F 278 D. Clinical Reimbursement Coordinator or designee will monitor 10 random resident medical records to determine activities of daily living including, functional status documentation is accurate. (Attachment R). Audits will be performed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive evaluations, then once a week until 100% success is achieved for 3 consecutive evaluations, then monthly X 1 if 100% success is achieved, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.	5/16/2016	
F 279 SS=E	These findings were reviewed with E1 (NHA) and E2 (DON) on 3/28/16 at 2:20 PM. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279			

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F 279	<p>Continued From page 18</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accuracy of the comprehensive care plan for three (R43, R126 and R129) out of 32 sampled residents for identified needs. For R43, the care plan did not address his contractures, blood pressure monitoring or constipation. R126's care plan did not include respiratory issues related to heart failure. For R129, the care plan did not address constipation. Findings include:</p> <p>Cross Refer F309, Example 1a. 1. Review of R43's clinical record revealed: 11/12/15 - Resident admitted to the facility with an interagency nursing communication form from the hospital documenting diagnoses including: high blood pressure, stroke with right sided weakness</p>	F 279	<p>F279</p> <p>A. R43 care plan was revised to include an intervention for monitoring blood pressures.</p> <p>B. Current residents care plans will be reviewed by a licensed nurse for accuracy, completeness and identified needs per their scheduled care plan review which typically is every 90 days.</p> <p>C. Nurse Practice Educator will re-educate staff completing care plans on policy for comprehensive care planning, including revisions as necessary to reflect current status. (Attachment R).</p> <p>D. Director of Nursing or designee will complete audit to verify 10% of scheduled weekly care plans are comprehensive and reflect current status. (Attachment S). Audits will be performed weekly until 100% success is achieved for 3 consecutive days, then monthly until 100% success is achieved for 3 consecutive evaluations if 100% success is achieved, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Improvement Committee for data collection and recommendations.</p>	5/16/16	

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F 279	<p>Continued From page 19 and three broken right ribs.</p> <p>11/12/15 admission physician orders for R43 included: - Oxycodone as needed every 6 hours for pain. This drug can cause constipation. - Miralax daily for constipation.</p> <p>January 2016 MAR - showed R43 received a PRN laxative 1/18/16.</p> <p>March, 2016 POS included four medications for control of R43's high blood pressure and a notation to call the physician if systolic BP over 160 or diastolic BP over 100.</p> <p>3/16/16 at 2:30 PM - Observation discovered R43's right arm was weak with minimal motion and he wore a wrist splint.</p> <p>Review of the resident's blood pressure readings recorded on the MAR from 12/26/15 through 3/21/16 (when a blood pressure medication was administered) found 121 readings with the systolic BP over 160 and/or diastolic BP over 100.</p> <p>3/16/16 review of R43's care plan found: - The care plan lacked a problem addressing constipation and treatment of deformities - Cardiovascular symptoms or complications related to high blood pressure and hyperlipidemia (initiated 11/13/15). Interventions included to monitor apical heart rate; observe for shortness of breath; monitor/report abnormal labs; monitor weight; and observe for mental status changes. The care plan interventions did not include monitoring the resident's blood pressure.</p> <p>During an interview on 3/23/16 interview with E5</p>	F 279	<p>F279</p> <p>A. R126 care plan was revised to include monitoring for heart failure and respiratory issues.</p> <p>B. Current residents care plans will be reviewed by a licensed nurse for accuracy, completeness and identified needs per their scheduled care plan review which typically is every 90 days.</p> <p>C. Nurse Practice Educator will re-educate staff completing care plans on policy for comprehensive care planning, including revisions as necessary to reflect current status. (Attachment R).</p> <p>D. Director of Nursing or designee will complete audit to verify 10% of scheduled weekly care plans are comprehensive and reflect current status. (Attachment S). Audits will be performed weekly until 100% success is achieved for 3 consecutive days, then monthly until 100% success is achieved for 3 consecutive evaluations if 100% success is achieved, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Improvement Committee for data collection and recommendations.</p>	5/16/16

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F 279	<p>Continued From page 20</p> <p>(RN, UM) at 10:50 AM E5 acknowledged the constipation and deformity problems were recently added to R43's care plan. While discussing interventions, E5 reviewed the current care plan and confirmed there was nothing in there about monitoring blood pressures..</p> <p>2. Review of R126's clinical records revealed:</p> <p>5/1/15 (last revised 3/4/16) care plan problem entitled risk for cardiovascular symptoms or complications related to high blood pressure and hyperlipidemia included interventions to administer medications and monitor for effectiveness and side effects and report abnormalities to physician; assess/monitor for chest pain; monitor vital signs as ordered; encourage activities as ordered and tolerated; monitor weight as ordered; observe for mental status changes and consult with physician as needed.</p> <p>Diagnoses recorded on R126's MARs from November, 2015 through February, 2016 included shortness of breath with activity, heart valve stenosis and history of a heart attack.</p> <p>March, 2016 POS included diagnoses of acute respiratory failure and heart failure.</p> <p>The resident's care plan problem did not include any mention of heart failure and associated respiratory issues.</p> <p>During an Interview with E5 (RN, UM) on 3/24/16 at 10:35 AM E5 stated R126 was sent to the emergency department on 3/5/16 with pneumonia and respiratory distress from heart failure. E5 reviewed the resident's care plan and confirmed</p>	F 279	<p>F279</p> <p>A. R129 care plan was revised to include monitoring for constipation.</p> <p>B. Current residents care plans will be reviewed by a licensed nurse for accuracy, completeness and identified needs per their scheduled care plan review which typically is every 90 days.</p> <p>C. Nurse Practice Educator will re-educate staff completing care plans on policy for comprehensive care planning, including revisions as necessary to reflect current status. (Attachment R).</p> <p>D. Director of Nursing or designee will complete audit to verify 10% of scheduled weekly care plans are comprehensive and reflect current status. (Attachment S). Audits will be performed weekly until 100% success is achieved for 3 consecutive days, then monthly until 100% success is achieved for 3 consecutive evaluations if 100% success is achieved, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Improvement Committee for data collection and recommendations.</p>	5/16/2016

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F 279	Continued From page 21 there was no care plan addressing respiratory concerns. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/28/16 at 2:20 PM. 3. Cross refer F309 example #3. Review of the clinical record for R129 revealed; R129's February and March 2016 physician order sheet included orders for two daily laxatives for constipation and the facility's Bowel Protocol for constipation. Review of the Documentation Survey Report for Bowel Continence documented that in February 2016 R129 had an episode of constipation with no BMs for 11 shifts and in March 2016 an episode with no BMs for 20 shifts. Review of R129's care plan lacked evidence that constipation had been identified as a concern. An interview on 3/24/16 at 9:45 AM with E5 (LPN) confirmed that there was no care plan initiated for the problem of constipation for R129. These findings were reviewed with E2 on 3/24/16 at 3:00 PM.	F 279			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide the necessary care and services in accordance with the comprehensive assessment and plan of care for three (R43, R126, and R129) out of 32 sampled residents by not consistently assessing pain location and/or severity before and/or after the administration of PRN pain medications. For R43 the facility also failed to obtain BP readings as ordered and failed to notify the physician for elevated BP readings. For R126 the facility failed to perform neurological assessments and failed to assess before and after several non-pain PRN medications. For R129, the facility failed to monitor and provide intervention for constipation. Findings include: Cross Refer F279, Example 1 1. Review of R43's clinical record revealed: 11/12/15 - Resident admitted to the facility with an interagency nursing communication form from the hospital documenting diagnoses including: high blood pressure, stroke with right sided weakness and three broken right ribs. a. Blood Pressure March, 2016 POS included four medications for control of R43's high blood pressure and an order to call the physician if systolic BP over 160 or diastolic BP over 100 written under the medication Hydralazine ordered 12/26/15. When nursing signed off the administration of each Hydralazine dose (6:00 AM, 2:00 PM and 10:00	F 309	F 309 A. R43 was discharged from the facility 4/2/2016 unable to provide corrective action . B. Current residents Medication Administration Record will be reviewed to determine current residents on blood pressure medications with parameters for holding medication or parameters that require notification of physician are completed as ordered. Physicians will be notified if blood pressure parameters are not met. Current residents receiving PRN pain medication had a pain evaluation completed to determine effectiveness of PRN pain medications. C. Nurse Practice Educator/designee will educate licensed nursing staff on the following policies: Physician Notification Including blood pressures above ordered parameters, Nsg 242 Vital Signs including, obtaining blood pressure as ordered to provide safe patient monitoring and Nsg 227 Pain Management, including documentation of a resident's pain scale pre and post administration of PRN pain medication and attaining resident specific acceptable pain level.	

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F 309	<p>Continued From page 23</p> <p>PM) on the MAR, there was space and notation to write the resident's blood pressure. No other BP readings were found in the record that corresponded with the times of the missing BPs on the MAR.</p> <p>Review of R43's MARs from December, 2015 through March, 2016 found thirty seven (37) instances where the BP was not assessed and recorded:</p> <ul style="list-style-type: none"> - January, 2016: 9 BPs out of 90 on January 5, 9, 10, 12, 14, 15, 21, 28 and 29. - February, 2016: 21 BPs out of 87 on February 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 16, 17, 20 and 21 (February 1, 2, 4, 6, 7 and 16 each were missing two BP readings) - March, 2016: 7 BPs out of 26 on March 2, 5, 6, 12, 14 and 18 (March 6 missing two BPs) <p>Review of the same December, 2015 through March, 2016 MARs and corresponding nursing notes discovered 121 times when R43's blood pressure was higher than the 12/26/15 ordered parameter to call the physician if systolic BP over 160 and/or diastolic BP over 100) and there was no evidence that the physician was notified:</p> <ul style="list-style-type: none"> - December, 2015: 9 BPs (starting 12/26/15) out of 15 readings - January, 2016: 44 BPs out of 90 readings - February, 2016: 42 BPs out of 87 readings - March, 2016: 26 BPs out of 65 readings (through 3/22/16) <p>During an interview on 3/23/16 at 11:00 AM with E2 (DON) the surveyor reviewed missing BPs on the MARs from 12/26/15 through 3/22/16. After showing E2 the Hydralazine order containing the parameter to call the physician if systolic BP over 160 or diastolic BP over 100, the surveyor asked</p>	F 309	<p>F 309</p> <p>D. Director of Nursing or designee will complete random reviews to determine compliance on 10% of residents with ordered blood pressure monitoring and physician notification as needed and documentation of effective PRN pain management. Audits will be completed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive evaluations, then weekly until 100% success is achieved for 3 consecutive weeks, then 1 month later, if 100% success is achieved, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.</p> <p>A. R126 was discharged from the facility on 4/19/2016 unable to provide corrective action.</p>	5/16/2016

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F 309	<p>Continued From page 24</p> <p>if the expectation would be for the nurse to contact the physician for each episode of high blood pressure above the parameter and explained that review of nursing notes from this time frame found no evidence that the physician was ever called even though there were numerous occasions when the resident's BP was higher than the parameter. E2 stated she would check with the nurse practitioner.</p> <p>Interview with E2 on 3/23/16 at 1:15 PM, during which E2 confirmed BPs were missing and stated she spoke with the NP about the parameter for calling the physician (the physician who wrote the order was no longer here). E2 said the NP wrote an order today (3/23/16) at 12:30 PM to decrease BP readings to once a day and removed the parameter of calling the provlder for elevated BP readings.</p> <p>The facility failed to assess R43's blood pressure 37 out of 203 instances and failed to contact the physician 121 out of 218 times when the blood pressure was higher than the ordered parameter.</p> <p>b. Pain R43 was admitted on 11/12/15 with diagnoses including three broken ribs and diabetic neuropathy. Admission physician orders for R43 included Tylenol and Oxycodone as needed for pain.</p> <p>11/13/15 - R43's care plan problem for alteration in comfort included the Intervention to use the pain scale [to determine severity of pain].</p> <p>11/19/15 Admission MDS documented the resident was cognitively intact with a BIMS of 15.</p>	F 309	<p>F 309</p> <p>B. Current residents with falls 4/15/2016 and after were reviewed to determine neurological assessment was being completed per policy. Current residents receiving PRN pain medication had a pain evaluation completed to determine effectiveness of PRN pain medications. Current residents receiving PRN medications were reviewed to determine completion of assessment and documentation by licensed nursing staff before and after administration of PRN medications</p> <p>C. Nurse Practice Educator/designee will educate licensed nursing staff on the following policies: Nsg 204 Neurological Assessment, including time frame of assessments and the importance of completing all areas of required assessment, Nsg 227 Pain Management, including documentation of a resident's pain scale pre and post administration of PRN pain medication and attaining resident specific acceptable pain level and Nsg 305 General Medication Administration regarding nursing assessment pre and post administration of non-pain medications, including but not limited to anti-diarrheal and inhalation medications.</p>		

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F 309	<p>Continued From page 25</p> <p>Facility policy entitled Pain Management (last revised 3/15/16) stated if PRN medications are given, document on the back of the MAR or on the PRN Pain Management Flow Sheet. Patients receiving interventions for pain will be monitored for the effectiveness and side effects in providing pain relief. Document effectiveness of PRN medications.</p> <p>Instructions on the top of the facility form entitled Pain Observation and Management Flow Sheet (dated 8/06) included to record all episodes of pain intervention, time of intervention, type of intervention, PRN medication, pain location, and severity of pain before and after intervention.</p> <p>3/22/16 review of R43's MARs and Pain Management Flow Sheets from November, 2015 through 3/22/16 discovered missing assessments before and after PRN pain medication as well as inconsistent use of the pain scale to determine pain severity. The resident's pain goal recorded on the pain flow sheet was recorded as 5 (five):</p> <ul style="list-style-type: none"> - November, 2015: 3 dates (November 14, 23 and 30) without location and/or severity before and/or after intervention. - December, 2015: 4 dates (December 6, 14, 20 and 25) without severity before and/or after intervention. - January, 2016: 3 dates (January 1, 16 and 30) without severity before and after intervention; there was no evidence on the MAR which medication the resident received 1/1/16. - February, 2016: 1 date (February 4) without location and severity before and after intervention. <p>On reverse side of the November 2015, December 2015 and January 2016 MARs some</p>	F 309	<p>F 309</p> <p>D. Director of Nursing or designee will complete random reviews to determine compliance with documentation on 10% of residents ordered PRN pain medications and 100% of falls for thorough completion of neurological assessment. Audits will be completed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive evaluations, then weekly until 100% success is achieved for 3 consecutive weeks, then 1 month later, if 100% success is achieved, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.</p> <p>A. R129 expired 4/29/2016 unable to provide corrective action.</p> <p>B. Current residents with no bowel movement in 9 shifts are being monitored via the alert dashboard of the electronic medical record with follow up by charge nurse to determine the Bowel Protocol was initiated and an abdominal assessment documented.</p>	5/16/2016

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F 309	<p>Continued From page 26</p> <p>nurses documented "helpful" after intervention which was not a pain severity using the pain scale.</p> <p>There was no evidence in the nursing notes of pain assessments corresponding with the missing severity/location noted on the December, 2015 through February, 2016 MARs and/or Pain Management Flow Sheet.</p> <p>During an interview with E2 on 3/23/16 at 1:20 PM E2 was informed about the missing assessments for PRN pain medication administration. E2 acknowledged the missing entries on the back of the MARs and/or Pain Management Flow Sheet but stated that staff wrote effective on the back of the PRN MAR. [The one instance when effective was written on the MAR (along with a severity rating before intervention) was not counted as a finding.]</p> <p>The facility failed to consistently assess R43's pain location and severity when PRN pain medication was administered on 11 (eleven) occasions.</p> <p>2. Review of R126's clinical record revealed:</p> <p>a. Neurological Assessment Facility policy entitled Assessment: Neurological (last revised 10/1/12) included when a patient sustains an injury to the head and/or has an unwitnessed fall, neurological assessment will be performed every 30 minutes for two hours, then every 1 hour for four hours, then every 4 hours for 24 hours [14 assessments in total].</p> <p>Instructions on the top of the facility form entitled Neurological Assessment Flow Sheet included</p>	F 309	<p>F 309</p> <p>C. Nurse Practice Educator or designee will educate current licensed nursing staff on the center specific Bowel Protocol, including documentation of an abdominal assessment in the medical record.</p> <p>D. Director of Nursing or designee will complete bowel alert reviews to determine compliance with documentation on 100% of residents that trigger for no bowel movement. Audits will be completed daily until 100% success is achieved for 3 consecutive days, then three times a week until 100% success is achieved for 3 consecutive evaluations, then weekly until 100% success is achieved for 3 consecutive weeks, then 1 month later, if 100% success is achieved, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.</p>	5/16/16	

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F 309	<p>Continued From page 27</p> <p>the following areas to be assessed: level of consciousness; pupil response; motor function for hand grasps, motor function for extremities, pain response; and vital signs.</p> <p>Review of Neurological Assessment Flow Sheets for falls from 2/26/16, 2/27/16, 3/1/16 and 3/3/16 discovered the following were missing aspects of the assessments (most of the time the vital signs were the only entry recorded on the flow sheets):</p> <ul style="list-style-type: none"> - 2/26/16: all 14 entries (0% compliant) - 2/27/16: 11 entries (21.4% compliant) - 3/1/16: 10 entries (28.6% compliant) - 3/3/16: 5 entries (64.3% compliant) <p>During an interview with E2 on 3/23/16 at 1:25 PM E2 acknowledged the missing entries on the neurological flow sheets. Since two of the forms were undated, E2 stated she would determine the correct date for each of the flow sheets, which was done by 3:30 PM.</p> <p>The facility failed to perform neurological assessment over 70% of the time after four falls in February and March, 2016.</p> <p>b. Pain</p> <p>9/10/15 - physician order included Tylenol PRN for pain or fever.</p> <p>10/1/15 - physician order included Tramadol PRN for pain.</p> <p>3/22/16 review of R126's MARs from November, 2015 through 3/22/15 discovered missing assessments before and after PRN pain medication as well as inconsistent use of the pain scale to determine pain severity:</p> <ul style="list-style-type: none"> - November, 2015: 11 (November 5, 9, 10, 12, 	F 309		

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F 309	<p>Continued From page 28</p> <p>14, 15, 21 x 2, 25, 27 and 30) without location and/or severity before and/or after intervention.</p> <p>- December, 2015: 3 (December 16, 19 and 20) without location and severity before and/or after intervention.</p> <p>- January, 2016: 8 (January 3, 8, 11, 12, 16, 17 and 30 x 2) without location and/or severity before and/or after intervention.</p> <p>- February, 2016: 5 (February 1, 4, 5, 7 and 14) without location and severity before and after intervention.</p> <p>c. Review of R126's December, 2015 through February, 2016 MARs revealed there was no evidence of an assessment before and after the administration of the following PRN medications:</p> <p>- December, 2015: 1 (December 14) out of 6 administrations of a medication for diarrhea.</p> <p>- February, 2016: 1 (February 22) out of 1 administration of an inhalation medication for shortness of breath</p> <p>During an interview with E2 on 3/23/16 at 1:30 PM E2 was informed about the missing assessments for PRN pain and non-pain medication administrations. E2 acknowledged the missing entries on the back of the MARs and/or Pain Management Flow Sheet but stated that some staff wrote "effective" on the back of the PRN MAR. [While several entries listed either "effective" or "relieved" after treatment assessment on the back of the MAR, they lacked a severity rating before the pain medication]</p> <p>These findings were reviewed with E1 (NHA) and E2 on 3/28/16 at 2:20 PM.</p> <p>3. Review of R129's clinical record revealed; Bowel Protocol: If no BM x 3 days MOM x1, no</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>BM x 4 days dulcolax 10 mg x1 rectally, no BM x 5 days fleets enema rectally, no results after enema call MD with prn use, do abdominal assessment for + bowel sounds all quads soft non tender chart exceptions</p> <p>R129's February and March 2016 physician order sheet included orders for two daily laxatives for constipation.</p> <p>Review of the Documentation Survey Report for Bowel Continence documented the following:</p> <ul style="list-style-type: none"> - 2/21/16 day shift through 2/24/16 night shift (11 shifts) no BM. - 2/25/16 evening shift through 3/2/16 night shift (20 shifts) no BM. <p>Review of the Medication Administration Record for February 2016 and March 2016 revealed that the bowel protocol was not initiated for constipation (9 shifts/3 days of no BM).</p> <p>Review of the Nurses' progress notes lacked evidence that an assessment of constipation had been conducted as indicated in the Bowel Protocol after 3 days with no BMs.</p> <p>Review of the facility's BM Audit tool indicated R129 was identified:</p> <ul style="list-style-type: none"> - On 2/25/16 as not having a BM in 11 shifts, had a BM that shift and had an abdominal assessment. No interventions was needed. - On 3/3/15 as not having a BM for 19 shifts and having a BM on 3/3/16 day shift without an intervention from the Bowel Protocol. There was no documentation of an assessment. 	F 309			

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F 309	Continued From page 30 An interview on 3/22/16 at 1:11 PM with E5 (LPN) revealed that if the resident has not had a BM in 9 shifts it would display on the dashboard of the electronic medical record. The facility also runs a report from the computer every morning to determine who has not had a BM in the last 3 days. An interview on 3/23/16 at 2:35 PM with E4 (RN, ADON) revealed that the BM Audit report is run every morning. She stated that on 2/25/16 R129 triggered for not having a BM in 11 shifts but had a BM before intervention was initiated. E4 went on to state that R129 did not show up in the BM audit report until 3/3/16 after 19 shifts with no BM. She was unsure why the resident did not start showing up after 3 days with no BM.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed for 1(R107) out of 32 residents, to offer and provide the necessary services related to eating. Findings include:	F 312		

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F 312	Continued From page 31 Review of R107's clinical record revealed: 12/30/15 - Nutrition assessment documented that R107 continued to feed herself and enjoyed eating in the dining room. 1/6/16 - Quarterly MDS assessment documented R107 required supervision (set up only) with eating and had severe cognitive impairment. 3/16/16 - Lunch observation in the main dining room: - 11:50 AM: R107 was served an egg salad sandwich that was cut in half along with cucumber/ tomato salad on a plate. Sandwich was then cut into quarters by staff. Resident had intermittent visible shaking/tremors of both arms/hands. - 11:56 AM: Resident had been sitting with her eyes closed and had not eaten anything from her plate. The dietary worker placed a piece of cake on a plate on the table next to R107 and asked the resident "You going to eat?". - 11:57 AM: Staff placed a piece of cake on the resident's fork and put the fork in the resident's right hand. While holding the fork in her right hand, the resident used her left hand to guide the fork to her mouth to eat the cake. [Later observation showed the resident uses her left hand to eat, yet the fork was placed in her right hand.] - 11:58 AM: The surveyor heard one resident state out loud [name of R107] "does better if you put it in her hand". Another resident, who was sitting about 12 feet away from the surveyor, said "[R107's first name] won't eat bread". - 11:59 AM: After staff removed the egg salad from the sandwich and discarded the bread, the	F 312	F 312 A. Staff assisted R107 with meals on the dates listed below since April 1 - 4/1/16, 4/2/16, 4/4/16, 4/5/16, 4/6/16, 4/7/16, 4/8/16, 4/9/16, 4/10/16, 4/11/16, 4/12/16, 4/13/16, 4/14/16, 1/15/16, 4/16/16, 4/17/16, 4/18/16, 4/19/16, 4/21/16, 4/22/16, 4/23/16, 4/24/16, 4/25/16, 4/26/16, 4/27/16, 4/28/16, 4/29/16, 4/30/16, 5/1/16, 5/2/16, 5/3/16, 5/4/16, 5/6/16. R107 expired 5/7/2016 at 0500 hrs. B. Each Unit Manager or designee will monitor residents with functional difficulties which may affect their ability to eat or drink independently or those who may be at risk for the need of increased eating services. C. Nurse Practice Educator or designee will instruct current nursing staff both licensed and unlicensed on Management of Nutrition and Hydration Policy including, interventions for residents with functional difficulties which may affect ability to eat and drink independently. Physician and Dietician will be notified of residents with a decline in eating for recommendations. Responsible Party will be notified of any decline.		

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F 312	Continued From page 32 resident began eating her meal. - 12:18 PM: R107 ate around 50% of the egg salad and cucumber/tomato salad. This percentage was recorded in the CNA documentation. 3/17/16 - Urine culture obtained since resident had increased sleepiness. Two days after collection the culture result showed that the resident had a UTI and was started on an antibiotic per physicians orders. 3/23/16 12:44 PM - 1:05 PM - Lunch observation with resident eating in her own room and surveyor observing from the hallway. - 12:44 PM: R107, seated in her wheelchair with a bedside table in front of her, was served a plate with tater tots, a grilled cheese sandwich that was cut in half, a glass of iced tea and small dish with canned sliced peaches. E7 (CNA) cut up the fruit into smaller pieces and said "Go ahead and start and I'll come back and check on you in a few minutes". - 12:45 PM: With the fork in her left hand R107 picked up a tater tot and placed it in her mouth then put down the fork. R107 picked up her napkin and, within a few seconds, spit out the tater tot into the napkin then placed the napkin on the table. R107 used her fork to place another tater tot in her mouth. She then spit it out into her right hand, then placed the tater tot on the table next to the plate. -12:50 PM: The resident picked up a green plastic cup containing a silk red flower and raised the cup to her mouth, then returned it to the table. After picking up and drinking some iced tea, R107 moved the dish of fruit away from her to the far side of the table. She touched the grilled	F 312	F 312 D. Director of Nursing or designee will complete random audits of breakfast, lunch and dinner both in the dining room and resident rooms to determine necessary services are provided related to eating. Audits will be completed daily for breakfast, lunch and dinner daily until 100% success is achieved for 3 consecutive days, then 3 times a week until 100% success is achieved for 3 consecutive audits, then once a week until 100% success for 3 consecutive audits. The audit will be conducted one month later and if 100% success is reached, we will conclude that the problem has been resolved. Findings of the audits will be reported to the Quality Assurance and Performance Improvement Committee for data collection and recommendations.	5/16/2016	

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F 312	<p>Continued From page 33</p> <p>cheese with her fingers but did not pick it up. - 12:55 PM: E7 entered the room and said "How you doing? Pick up the sandwich." R107 picked up a half of sandwich then returned it to the plate without eating any of it. E7 sat next to R107 and asked the resident to pick up one of the tater tots and take a bite. Resident responded "I don't like them". - starting at 12:58 PM: E7 began to feed the resident peaches using the fork, which R107 accepted and ate. The CNA said "I'm making sure you get lunch, it's a long time until dinner. I know you like peaches, you usually eat your fruit." After 3-4 bites of peaches E7 asked R107 is she was done and encouraged her to finish the iced tea and take a bite of her sandwich. E7 carried the meal dishes with uneaten sandwich and tater tots to the designated cart in the hallway by the Unit 2 nursing station.</p> <p>3/23/16 at 1:07 PM - While in the hallway by the dirty dish cart by the Unit 2 nursing station, the surveyor heard E8 (CNA) say to E7 that E4 (UM) said R107 "can't eat in the dining room. They sent her back cause she didn't do nothing but sleep".</p> <p>Review of CNA documentation on meal intake found: - Resident had been mainly independent with eating until 3/16/16. From March 16 through March 21 (2016) the resident needed Increased assistance with meals (limited assistance 3 times; extensive assistance 3 times; total dependence 6 times. [The decrease in meal time independence corresponds to the development of the UTI.] - Intake from lunch observation on 3/23/16 was listed as 75%.</p>	F 312			

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F 312	Continued From page 34 The facility failed to identify the change in R107's level of alertness, decrease in independence and need for increased assistance with meals during this infectious process. There was no care plan developed for increased assistance during meals. During an interview with E12 (Director of Dining Services) on 3/28/16 at 8:20 AM to discuss R107's preferences, E12 verified the resident was ordered a regular diet and that no likes or dislikes were found on R107's diet preference sheet. Surveyor discussed the meal observations and the fact that another resident had told the surveyor that R107 would not eat bread. E12 stated he would talk with the dietitian to determine resident preferences. During an interview with R107 on 3/28/16 at 9:12 AM to determine food preferences, R107 was not able to verbalize likes or dislikes. The facility failed to assist the resident with activities of daily living specifically eating.	F 312			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	F 329 A. R126 correct diagnosis for Lasix and prednisone were obtained 3/24/2016. Resident was discharged from the facility 4/19/2016.		

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F 329	<p>Continued From page 35 combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that the drug regimen for 2 (R126 and R129) out of 32 sampled residents was free from unnecessary drugs. For R126, there was a lack of rationale for use of two medications and lack of monitoring for a PRN medication for anxiety. For R129, the facility failed to monitor side effects using the AIMS and failed to monitor pulse for a heart medication. Findings include:</p> <p>1. Review of R126's records revealed: a. Rationale for Medications</p> <p>4/30/15 - Admission to the facility with multiple diagnoses including a history of a heart attack, heart failure and lupus.</p> <p>2/25/16 - Readmission orders included:</p>	F 329	<p>F329</p> <p>B. Current medical records were reviewed to determine medications had an appropriate diagnosis or rationale for use and PRN psychotropic medications administered had documentation to support the need for the medication and effectiveness for the targeted behavior.</p> <p>C. Nurse Practice Educator or designee will instruct current licensed nursing staff on F329 483.25(l) Drug Regimen is Free From Unnecessary Drugs, including but not limited to excessive dose, excessive duration, without adequate monitoring, without adequate indication for use and on Procedure for Management of Challenging Behaviors including, use of the Behavior Monitoring and Interventions Flow Record to document the behavior for which medication is being given, the non-pharmalogical intervention attempted and the effectiveness of the medication.</p> <p>D. Director of Nursing or designee will complete random audits on</p>	

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F 329	<p>Continued From page 36</p> <p>- Lasix daily with the rationale as "diuretic". Instead of the diagnosis, the category of medication was included in the order.</p> <p>- Prednisone daily with the rationale as "steroid". Instead of the diagnosis, the type of medication was included in the order.</p> <p>During an interview with E5 (RN, UM) on 3/24/16 at 10:30 AM about the reason for Lasix and Prednisone listing the classification of medication instead of why this resident needs the drugs, E5 stated she would get clarification from the NP. At 11:13 AM the same day E5 provided copy of order containing R126's diagnoses for the two medications (heart failure for Lasix; lupus for Prednisone).</p> <p>b. PRN Medication Monitoring 4/30/15 - Admission to facility.</p> <p>5/1/15 - Care plan problem of exhibits distressed mood symptoms as evidenced by depression, anxiety and insomnia. Interventions included to medicate resident per physicians' orders (PRN) and monitor for effectiveness; observe for signs/symptoms of depression or anxiety; and psychiatric consult as needed.</p> <p>11/16/15 - Physician order included PRN medication (Xanax) for anxiety.</p> <p>2/26/16 - Physician orders written within a day of 2/25/16 readmission included a medication for anxiety to be routinely given twice a day and another medication (Xanax) to be given PRN for anxiety.</p> <p>Review of MARs from November 2015 through February 2016 revealed 4 (four) doses of PRN</p>	F 329	F329	5/16/2016	

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F 329	<p>Continued From page 37</p> <p>Xanax lacked evidence of assessment before (to determine the need for the medication) and after (to determine the effectiveness of the medication) the administration: - January, 2016: 1 (January 28) out of 3 doses - February 2016: 3 (February 13, 18 and 20) out of 12 doses</p> <p>During an interview with E2 (DON) on 3/23/16 at 1:30 PM E2 was informed about the missing assessments for PRN anxiety medication administrations. E2 acknowledged the missing entries on the back of the MARs.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 3/28/16 at 2:20 PM.</p> <p>2. The following was reviewed in R129's clinical record:</p> <p>a. R129 had physician's orders dated 8/31/15 for the medication ABHR gel to be applied three times a day. The compound drug contains Haldol which in an antipsychotic medication.</p> <p>11/4/14 last revision 3/23/16 - A care plan for resident is at risk for complications related to the use of psychotropic drugs medication ABHR with interventions that included AIMS testing per protocol.</p> <p>Review of the clinical record lacked evidence of an AIMS assessment being conducted.</p> <p>3/23/16 at 2:35 PM - Interview with E4 (RN, ADON) confirmed that there had been no AIMS assessment conducted and one was done today.</p> <p>b. R129 had physician's orders dated 6/20/15 for</p>	F 329	<p>F329</p> <p>A. R129 had an AIMS assessment completed and an order written to hold digoxin for pulse less than 55 3/23/2016.</p> <p>B. Current residents Medication Administration Record were audited to determine compliance with pulse monitoring and parameters for holding digoxin, if needed physician orders were obtained. Residents with orders for ABHR were reviewed to determine Aims assessment was completed in the last 6 months, if not an Aims was completed.</p> <p>C. Nurse Practice Educator or designee will instruct current licensed nursing staff on F329 483.25(l) Drug Regimen is Free From Unnecessary Drugs, including but not limited to excessive dose, excessive duration, without adequate monitoring, without adequate indication for use and antipsychotic medications require an AIMS assessment to monitor abnormal involuntary movements every 6 months.</p> <p>D. Director of Nursing or designee will complete audits on 100% of residents receiving antipsychotic medications, including ABHR for AIMS assessment within the last 6 months. Audits will be completed monthly x 3 months.</p>	

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F 329	Continued From page 38 the medication Digoxin to treat an issue with heart rhythm. The order did not include the need to take a pulse or parameters to hold the medication for a low pulse reading. The clinical record did contain occasional pulse readings throughout each month but not daily with the administration of the medication. Nursing 2015 Drug Handbook documents for Digoxin that before giving the drug the pulse should be taken for one minute. An interview on 3/23/16 at 2:35 PM with E4 confirmed that a pulse reading was not being done before administration of the Digoxin. E4 provided a newly obtained physician order dated 3/23/16 to hold the medication for a pulse of less than 55. These findings were reviewed with E2 on 3/24/16 at 3:00 PM.	F 329	F329 Director of Nursing or designee will audit 10% of residents on digoxin to determine compliance with pulse monitoring and holding medication per physician parameter. Audits will be completed daily until 100% success is achieved for 3 consecutive evaluations, then weekly until 100% success is achieved for 3 consecutive evaluations, then 1 month later if 100% success is achieved, we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.	5/16/16
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime dally. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a	F 368	F 368 A. Nursing Home Administrator met with the Resident Council President to discuss the change in Breakfast and Dinner meal times on 4/22/16. A letter was sent out to all residents on 4/29/16 notifying all residents of the upcoming meal time changes. B. The time change for meals are to be implemented on 5/4/16. Breakfast will be served at 7:15 AM and dinner will be served at 5:15 PM.	

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F 368	<p>Continued From page 39 resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to ensure the resident group agreed to more than 14 hours between the evening meal and breakfast. Findings include:</p> <p>Review of the paper listing meal times provided by the facility on 3/16/16, it was found that more than 14 hours passed between dinner and breakfast. In the dining room and on Unit 2, the time frame was 15 hours. On Unit 1, the time span was 14 hours and 15 minutes.</p> <p>Resident SS1 stated on 3/16/16 at 1:45 PM, that they (facility) wouldn't give her a sandwich when she asked. The resident admitted to hiding snacks provided by her family.</p> <p>Review of Resident Council minutes from September 2015 through March 2016 found no evidence of discussion or approval of providing a substantial snack due to the length of time from dinner to breakfast.</p> <p>During an interview with E12 (Director Dining Services) on 3/28/16 at 8:20 AM, when asked what snacks were available for residents after dinner E12 said chips, cheese-its, pretzels and nilla wafers. Ordered snacks like milk, sandwiches, shakes and ordered snacks like milk, sandwiches and shakes are sent to the floor between 7:30 PM and 8:00 PM. E12 added</p>	F 368	<p>F 368</p> <p>C. NHA will discuss meal times annually every April with the Resident Council.</p> <p>D. 1. The Nursing Supervisor or designee will monitor the meal service to determine that the meals are served at 7:15 AM for breakfast and 5:15 PM for dinner (Attachment GG). The audit will be performed twice daily until there is 100% success for 3 consecutive days. Then the audit will be conducted twice a day, three times a week until there is 100% success for 3 consecutive evaluations. Then the audit will be conducted twice a day, one day a week until there is 100% success for 3 consecutive weeks. The audit will be conducted one month later and if 100% success is reached, we will conclude that the problem has been resolved. Findings will be reported to the Quality Assurance and Performance Committee for data evaluation and recommendations.</p>	5/16/2016	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2016
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F 368	<p>Continued From page 40</p> <p>that nursing (supervisor) has access (key) to the kitchen since "we have sliced meats and bread available" to make sandwiches. E12 acknowledged that nursing does use it (key) because sometimes we have a mess to clean up in the morning.</p> <p>During an interview with E100 (Resident Council President for the past several years) on 3/28/16 at 8:30 AM denied any discussion about time frame from dinner to breakfast being over 14 hours as long as substantial snacks were available to residents. E100 stated that snack items (chips, pretzels, nilla wafers) are sent from the kitchen "but once they're gone, they're gone". E100 added that she thought sandwiches were only for diabetics. E100 commented that she used to get half sandwich and celery sticks (she asked for them) every day but they changed it to every other day due to them "cutting back on snacks". E100 said that a lot of the time by 10:00 PM many of the snacks are gone.</p> <p>Interviews were conducted on 3/28/16 with residents to determine the availability of snacks after dinner;</p> <ul style="list-style-type: none"> - 9:30 AM - SS2 informed the surveyor she asked for a sandwich last night (3/28/16) around 9:30 PM and was told there weren't any. "If the other man is on he'd get one for me." SS2 said she can't keep food in her room cause "If they find food in your drawer, they yell at you". - 9:50 AM - SS3 stated yogurt is available. - 9:53 AM - R145 commented that "sometimes they do and sometimes they don't". <p>During an interview with E2 (DON) on 3/28/16 at 10:57 AM to inquire about documentation of resident council approval for the time frame being</p>	F 368			

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F 368	Continued From page 41 more than 14 hours from dinner to breakfast, E2 stated she would check into the matter. E2 was informed at that time that some residents stated that snacks were not always available after dinner. By 12:45 PM the same day E2 informed the surveyor that there was no documentation in resident council minutes and E2 would make the recommendation to discuss the topic annually.	F 368			
F 428 SS=D	These findings were reviewed with E1 (NHA) and E2 on 3/28/16 at 2:20 PM. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that for 1 (R129) out of 32 residents the pharmacist identified irregularities in the monthly medication reviews. The AIMS assessment was not being done for the use of an antipsychotic medication and the pulse was not being monitored for the use of a heart medication. For 1 out (R128) out of 32 residents the physician failed to respond to the pharmacist's recommendation. Findings include:	F 428	F 428 A. R129 AIMS assessment and order to monitor pulse for cardiac medication was completed 3/23/2016. B. Current medical records will be reviewed to determine residents on cardiac medications requiring monitoring of pulse or blood pressure have the required monitoring in place. Consultant pharmacist will submit data regarding compliance with Aims assessments and monitoring of cardiac medications as required for reviews 4/2016 and 5/2016 at quarterly QAPI committee meeting. C. Director of Nursing will review the findings of F428 with the pharmacy consultant.		

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F 428	Continued From page 42 1. Cross refer F329 example #2 The following was reviewed in R129's clinical record: - R129 had physician's orders originating 8/31/15 for the medication ABHR gel to be applied three times a day. The compound drug contains Haldol which in an antipsychotic medication. - R129 had physician's orders originating 6/20/15 for the medication Digoxin to treat an issue with heart rhythm. The order did not include the need to take a pulse or parameters to hold the medication for a low pulse reading. The pharmacist reviewed the medication regime on 10/2/15, 11/4/15, 12/3/15, 1/4/16 and 3/4/16. There was no review found for February 2016. The pharmacist failed to identify that the AIMS assessment and the pulses were not being conducted. 3/23/16 at 2:35 PM - Interview with E4 (RN, ADON) confirmed that there had been no AIMS assessment conducted and one was done today and confirmed that a pulse reading was not being done before administration of the Digoxin. E4 provided a newly obtained physician order dated 3/23/16 to hold the medication for a pulse of less than 55. There was no evidence that the pharmacist identified these concerns during the monthly review. 2. During review of R128's medical record, the	F 428	F 428 D. Director of Nursing or designee will randomly audit 10% of current medical records to determine pharmacist has recommended monitoring of pulse or blood pressure as needed for cardiac medications and recommended completion of AIMS assessment if resident receiving antipsychotic medication. Audits will be completed daily until 100% success is achieved for 3 consecutive evaluations, then weekly until 100% success is achieved, then 3 x week until 100% success is achieved for 3 consecutive evaluations, then 1 month later, if 100% success is achieved we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.	5/16/2016	

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F 428	Continued From page 43 Pharmacy Consultation Report, dated 1/4/16 noted an irregularity which required a physician response. There was no indication that the physician responded to the pharmacist 's concern. During an interview on 3/24/16 at 11:40 AM E2 (DON) confirmed that Consultation Reports are mailed to the facility. During a second interview on 3/24/16 at 2:40 PM E2 confirmed that R128's Consultation Report for 1/4/16 was never acted upon. These findings were reviewed with E1 (NHA) and E2 on 3/28/16 at 2:20 PM.	F 428	F 428 A. R128 dilantin level was drawn 3/25/2016 and was within normal limits. B. Consultant pharmacist will follow up on previously noted irregularities monthly to determine follow up the physician has occurred. C. Director of Nursing will review the findings of F428 with the pharmacy consultant. D. Director of Nursing or designee will randomly audit 10% of monthly pharmacist recommendations to determine physician follow up has occurred.	5/16/16	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	Audits will be completed monthly until 100% success is achieved for 3 consecutive evaluations if 100% success is achieved we will conclude that the problem has been resolved. Findings of audits will be reported to the Quality Assurance and Performance Improvement Committee for data evaluation and recommendations.		

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F 431	<p>Continued From page 44</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that expired medications were removed from 2 out of 2 medication carts surveyed. Additionally several unlabeled medications were found in 1 out of 2 surveyed medication carts. Findings include:</p> <p>1. Observation on 3/1/6/16 at 9:10 AM of the Unit 2 (long hall) medication cart revealed the following blister packs of medications were expired: - One pack Tylenol with 30 tablets expired 5/31/15. - One pack Ibuprofen with 30 tablets expired 9/30/15. - One pack Mucinex with 30 tablets expired 12/2015. - One pack Colace with 25 tablets expired 2/29/16. - One pack Colace with 19 tablets expired 2/29/16.</p>	F 431	<p>F431</p> <p>A. Expired tylenol, ibuprofen, mucinex and colace were removed from Unit 2 medicine cart and destroyed on 3/1/2016</p> <p>B. Medication carts and rooms on Unit 2 were audited by licensed nurse to determine there were no other expired biologicals and medications.</p> <p>C. Pharmacy consultant will perform monthly audits on each medication cart to identify any expired medications and trends in practice. Medication carts/rooms will be audited monthly by nursing for expired medications, discrepancies will be reported to Director of Nursing or designee to determine root cause of practice if needed.</p> <p>D. Director of Nursing or designee will complete random audits of medication carts/rooms to determine compliance with destruction of expired medications and biologicals monthly x 3, if 100% success is achieved we will conclude issue is resolved. Findings of audits will be reported to the Quality Assurance and performance Improvement Committee for data evaluation and recommendations.</p>	5/16/2016	

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F 431	<p>Continued From page 45</p> <p>During an interview with E3 (LPN) on 3/16/16 at 9:35 AM, E4 confirmed these oral medications were expired.</p> <p>2. Observation on 3/24/16 at 12:40 PM of the Unit 1 (long hall) medication cart revealed the following unlabeled and expired medications:</p> <p>a. Unlabeled medications:</p> <ul style="list-style-type: none"> - One Preparation H suppository. - One vial of Albuterol used for nebulizer treatment. - Two unit doses of Restasis eye drops. - Two tubes of Clotrimazole cream. <p>b. Expired medications:</p> <ul style="list-style-type: none"> - One syringe of heparin flush expired 2/2016. - Five bottles of insulin, each with a sticker containing a space for the nurse to write the date opened and a pre-printed statement that the bottle was to be discarded 28 days after opening: - Novolog Insulin with open date 2/13/16. - Lantus Insulin with open date 2/14/16. - Lantus Insulin with open date 2/16/16. - Lantus insulin opened but undated. - Levemir Insulin with open date 2/12/16 contained the same sticker to discard, yet manufacturer instructions indicated this insulin would expire 42 days after opening (3/25/16). <p>During an interview with E6 (LPN) on 3/24/16 at 1:02 PM, E6 confirmed the unlabeled medications and the opened dates (including undated bottle) on the insulin.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 3/28/16 at 2:20 PM.</p>	F 431	<p>F431</p> <p>A. Expired preparation H, albuterol neb, restasis, clotrimazole, heparin flush and expired insulins were removed from station 1 medicine cart and destroyed on 3/24/2016</p> <p>B. Medication carts and rooms on Unit 1 were audited by licensed nurse to determine there were no other expired biologicals and medications.</p> <p>C. Pharmacy consultant will perform monthly audits on each medication cart to identify any expired medications and trends in practice. Medication carts/rooms will be audited monthly by nursing for expired medications, discrepancies will be reported to Director of Nursing or designee to determine root cause of practice if needed.</p> <p>D. Director of Nursing or designee will complete random audits of medication carts/rooms on each unit to determine compliance with destruction of expired medications and biologicals monthly x 3, if 100% success is achieved we will conclude issue is resolved. Findings of audits will be reported to the Quality Assurance and performance Improvement Committee for data evaluation and recommendations.</p>	5/16/2016



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center Nursing Home

DATE SURVEY COMPLETED: March 28, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from March 16, 2016 through March 28, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 112. The Stage 2 sample totaled 32 residents.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 28, 2016 F241, F244, F246, F272, F278, F279, F309, F312, F329, F368, F428, and F431.</p>		

Provider's Signature Doris Schonbrunn Title Administrator Date 5/23/16



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AND SOCIAL SERVICES**

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3201.6.9.2.4	<p>Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.</p> <p>This requirement is not met as evidenced by: Based on record review and interview. The facility failed to ensure that for one (E9) out of six sampled employees that the base line two step tuberculin skin test was performed.</p> <p>A randomized list sample of six employees was submitted to the facility requesting dates of their baseline two step tuberculin skin test. E9's (RN) first test date was 10/20/14, the second test date was 5/18/15; about seven months later.</p> <p>The Center for Disease Control and Prevention in the "Latent Tuberculosis Infection: Guide for Primary Health Care Providers" indicates the second test in the two step tuberculin skin test are to be conducted within one to three weeks of the first test date.</p> <p>3/28/16 12:10 PM E10 Infection Control Nurse confirmed the two step administration dates as accurate.</p> <p>These findings were reviewed with E1 (NHA) and E2(DON) on 3/28/16 at 2:20 PM.</p>	<p>3201.6.9.2.4</p> <ul style="list-style-type: none"> A. Employee will be given a 2 step PPD. B. Current employee files will be reviewed by the Director of Nursing or Designee to determine the tuberculin skin testing adheres to Genesis HealthCare Policy. C. Nurse Practice Educator will be re-educated on the Genesis HealthCare Policy for two step tuberculin skin test (Attachment A). D. Director of Nursing or Designee will conduct a monthly audit to determine tuberculin skin testing was conducted appropriately per policy. (Attachment B). These audits will be on-going until results demonstrate 100% success for three consecutive months. Findings will be reported to the Quality Assurance and performance Improvement Committee for data collection and recommendations. 	<p>5/16/2016</p>

Provider's Signature *Dore Schurbrunn* Title Administrator Date 5/23/16