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: Foulk Manor South

DATE SURVEY COMPLETED: January 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning December 28, 2016 and ending January 3, 2017. The facility census on the entrance day of the survey was 34 residents. The survey sample was composed of 5 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures. **Abbreviations/definitions used in this state report are as follows:** ADL- activities of daily living such as bathing and dressing; CNA-Certified Nurse's Aide; DON – Director of Nursing; ED – Executive Director; ER – Emergency Room; FSD – Food Service Director; HS – hour of sleep/bedtime; INR – International Normalized Ratio/test used to learn how fast the blood clots in patients receiving Coumadin[blood thinner] (Warfarin); LPN – Licensed Practical Nurse; LTC- Long Term Care; MAR – Medication Administration Record; mg – milligram; NN's- nurses notes; NP – Nurse Practitioner; PRN- as needed; Q – every; RN – Registered Nurse; TARs- Treatment Administration Record; Abrasion - superficial wound caused by some mechanical process (friction or trauma); Acute – sudden onset; Acetaminophen – pain medication; Blister pack – pre-formed plastic	

Provider's Signature [signature] Title Executive Direc[tor] Date 3/2/17

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	finding, treating and the prevention of heart disease and associated blood vessels; CT Scan – computerized tomography scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels and soft tissues inside your body; Continent – control of bladder function; Incontinent – loss of bladder function; Coumadin - oral anticoagulant medication (blood thinner); Coccyx-tail bone; c-diff – infection that causes diarrhea; Data Collection Tool (DCT)– facility nursing form used to record assessments; Dementia– a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation **OR** loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dermatology- a branch of Medicine dealing with skin, nails, hair and related disease; IDDM – insulin dependent diabetes mellitus; Intracranial – inside the skull; Incontinence/incontinent - loss of control of bladder; Laceration – cut/open area in the skin; Neurological Assessments - series of simple questions and physical tests to determine if the nervous system is impaired; Pericare – washing the genitals and anal area during a bath; Pressure ulcer – bedsores; Prostate - gland surrounding the neck of the bladder in a male; r/t-R/T-related to;	

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	Recapitulation/recap – monthly process of verifying physician's orders; Resident Care Card- form used by CNA's that identifies specific care needs of a resident including toileting needs, orientation level; Serous sanguineous-blood and liquid part of the blood; s/s – signs and symptoms; Stage 2 pressure ulcer – red broken skin; Turgor- elasticity; Vital signs - clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure that indicate the state of a patient's essential body functions; Voiding diary - record of urinating for 72 hours and/or 3 days.	
3201	**Regulations for Skilled and Intermediate Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**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 the Regulation, as fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as**	

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	evidenced by: **F164** **§483.10*(h)* Privacy and Confidentiality** **The resident has a right to personal privacy and confidentiality of his or her personal and *medical* records.** **§483.10(*h*)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.** ***§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.*** **This requirement is not met as evidenced by:** Based on observations and interview, it was determined that for two (R3 and R4) out of 4 sampled residents, the facility failed to provide personal privacy and confidentiality of R3 and R4's Care Cards. Findings include: 1. Observation on 12/28/16 at 11:30 AM of R3's shared bathroom revealed R3's Care Card posted on the door. The Care Card listed R3's physical needs, bowel and bladder patterns and toileting needs, safety needs, activities of daily living needs, nutrition needs, ambulation/mobility needs, skin care needs and his likes/dislikes.	Compliance Date March 31, 2017 F164 S483.10(h)(l)(3) 1. R3 and R4 were not adversely affected by this practice. The care cards for residents R3 and R4 were immediately removed from bathroom doors. 2. All residents have the potential to be at risk for this practice. Care cards were immediately removed from bathroom doors for all residents. 3. Resident care cards will now be kept in a secure and confidential area as to protect our resident's right to privacy. Nursing staff will be in-serviced by the DON/designee on where care cards will be kept to ensure resident privacy and appropriate staff access. 4. The Director of Nursing will audit weekly for 4 weeks all resident rooms to ensure card cards are not visible and privacy protected for all residents. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	On 12/29/16 at 3:20 PM, during a second observation with E2 (DON), she confirmed the finding and immediately moved R3's Care Card from the door in the shared bathroom and posted it inside R3's closet. The facility failed to provide personal privacy and confidentiality of R3's Care Card. 2. R4's Resident Care Card, which identifies the resident's specific care needs was observed with E9 (LPN) present on 1/3/17 at approximately 10:30 AM. The Resident Care Card was taped to the inside of his bathroom door which is shared between two rooms and could be viewed by other residents using the same bathroom. Findings were discussed with E1 (ED) and E2 (DON) during the exit conference on 1/3/17 at approximately 1:50 PM. **F241** ***§483.10(a)(1)* A facility must *treat each resident with respect and dignity and care for each resident* in a manner and in an environment that promotes maintenance or enhancement *of his or her* quality of life, *recognizing each resident's individuality. The facility must protect and promote the rights of the resident.*** **This requirement is not met as evidenced by:** Based on observation and interview, it was determined that the facility failed to promote care for 14 out of 17 residents in dining room in The Garden and for 4 (SS2, SS3, SS7, and SS8) out of 8	F241 S483.10(a)(1) 1. A. No resident was adversely affected by this practice. We cannot retroactively correct the practices cited for those residents found to be affected but we can ensure going forward the following. B. All residents are at risk for not being asked if they would like a clothing protector placed on them by staff. All residents will be asked by staff prior to all meals if they would like to have a clothing protector placed on them. C. Staff will be educated on the resident's right to be treated with dignity and respect in an environment that must protect and promote the rights of the resident's individuality. Also, staff will be educated on how to effectively communicate with residents when

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	subsampled residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. The facility failed to ask multiple residents if they wanted clothing protectors prior to applying them; they failed to knock and/or ask permission from R5 and R6 prior to entering their room; they failed to provide assistance with breakfast to a resident who watched others eat for several minutes; and they failed to ensure that a finger stick test was not performed in the presence of other residents. Findings include: 1A. During the dining observation of lunch on 12/28/16 from approximately 12:10-12:40 PM in The Garden (locked dementia unit), it was observed that 14 out of 17 residents had bibs or clothing protectors placed by staff without the residents being asked if they wanted one. 1B. During the same dining observation, one of 17 residents was feeding herself soup when E7 (CNA) pulled the residents chair back without saying anything and placed a clothing protector on her. 2A. On 12/29/16 at approximately 8:05 AM during the medication pass in the Healthcare unit, E3 (LPN) was observed walking directly into SS2's room to give medications. E3 failed to respect SS2's private space by knocking on the door and/or requesting permission to enter. 2B. On 12/29/16 at approximately 8:10 AM during the medication pass, E3 was	offering/applying clothing protector's to residents by DON/designee. D. The Director of Nursing or designee will audit weekly for 4 weeks all residents being offered clothing protectors to ensure they are being offered with dignity and respect. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 2. A. No resident was adversely affected by this practice. We cannot retroactively correct the practices cited for those residents found to be affected but we can ensure going forward the following. B. All residents are at risk of staff not knocking on their room door prior to entering. C. Staff will be educated on the resident's right to be treated with dignity and respect in an environment that must protect and promote the rights of the resident's individuality. Also, staff will be educated on knocking on resident's doors prior to entering by DON/designee. D. The Executive Director or designee will audit weekly for 4 weeks staff entering resident's rooms to ensure they are knocking prior to entering. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 3. A. No resident was adversely affected by this practice. We cannot retroactively correct the practices cited for those residents found to be affected but we can ensure going forward the following. B. Resident's with diabetes are identified as

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	observed walking directly into SS3's room to give medications. E3 failed to respect SS3's private space by knocking on the door and/or requesting permission to enter. 2C. On 12/29/16 at approximately 8:15 AM, E2 (DON) was observed walking directly into SS2 and SS3's room without knocking on the door and/or requesting permission to enter. E2 failed to respect SS2's and SS3's private space by knocking on the door and/or requesting permission to enter. Findings were reviewed with E2 during an interview on 1/3/17 at approximately 12 PM. E2 stated that E3 reported to her (E2) that she failed to knock or ask permission to enter SS2 and SS3's room during the medication pass on 12/29/16. 3A. On 12/28/16 at 8:10 AM during breakfast service, staff was observed distributing bowls of hot cereal to residents in the Healthcare dining room, including to SS8 (name not obtained) sitting by herself at a corner table. SS8 watched the others eat for 30 minutes before staff came to feed her at 8:40 AM. 3B. On 12/28/16 at 11:55 AM, E4 (LPN) was observed entering the Healthcare dining room and heading toward a table with three residents. E4 told one of the residents, SS7, she needed to do a finger stick test on her. As E4 pierced the SS7's finger, SS7 cried out loud as the other residents looked on. Interview with E4 on	having the potential to be affected by this deficient practice. The staff member involved was inserviced immediately on proper finger stick testing procedures as well as resident's right to privacy and dignity. C. Licensed nursing staff will be educated on the resident's right to be treated with dignity and respect in an environment that must protect and promote the rights of the resident's individuality during the finger stick testing procedure by DON/designee. D. The DON or designee will audit weekly for 4 weeks LPN staff administering finger stick testing to ensure resident's rights are being observed and protected during this procedure. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 4. A. No resident was adversely affected by this practice. We cannot retroactively correct the practices cited for those residents found to be affected but we can ensure going forward the following. B. All residents are at risk of not being served their meal in a timely manner. Staff will ensure residents in the same dining room will be served at the same time during all meals. C. Staff will be educated on the resident's right to be treated with dignity and respect in an environment that must protect and promote the rights of the resident's individuality while dining at Foulk Manor South. Staff will also be educated on serving all residents in a timely manner during meal times by DON/designee. D. The Executive Director or designee will audit weekly for 4 weeks the meal delivery

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	12/28/16 at 1:50 PM revealed the facility was trying to see if SS7, a resident in a locked dementia unit (The Gardens) would benefit from being placed in a different setting. This was confirmed by E2 on 1/3/17 at approximately 12 PM, who stated SS7's family requested to place the resident in a different environment to see if there would be positive results.	process to our residents to ensure residents are served timely and treated with dignity and respect. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.
	F253 ***§483.10(i)* (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.** **This requirement is not met as evidenced by:** Based on observations and interview, it was determined that for two rooms (room 158A and 182) out of 4 sampled rooms, the facility failed to maintain an environment that was clean and free from offensive odors. Findings include: 1. Observations on 12/28/16 at 11:30 AM and 12/29/16 at 3:20 PM of room 182's shared bathroom revealed a dirty elevated toilet seat and toilet bowl, a presence of urine odor and two smears of a dark substance on the white wall directly behind the toilet. During the second observation with E2 (DON) on 12/29/16 at 3:20 PM, she confirmed the findings. The facility failed to maintain cleanliness of resident room 182 and keep it free from offensive odors. 2. Observation of resident room 158A on 1/3/17 at 9:25 AM revealed multiple areas	F253 S483.10(i) 1. Upon revelation of the surveyor's findings the bathroom to room 182 was properly cleaned and disinfected. Also, the bathroom in room 158A was painted. 2. All resident's bathrooms have the potential to be affected by unsanitary conditions and paint chipped walls. Environmental Services and Maintenance staff will be educated on bathroom cleanliness procedures and paint chipped walls. 3. The Executive Director or designee will audit weekly resident bathrooms for cleanliness and paint chipping walls. 4. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	of chipped paint along the right side of the wall upon entering the room and on the room and bathroom doorways. Findings were reviewed with E2 (DON) during an interview on 1/3/17 at approximately 12 PM. **F279** **§483.20(k) Comprehensive Care Plans** **(1) 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. The care plan must describe the following:** **(1)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;** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview, it was determined that for one (R2) out of 4 sampled residents, the facility failed to ensure that a comprehensive care plan was developed for R2's problem related to the actual occurrence and/re-occurrence of a Stage 2 coccyx pressure ulcer. Findings include:	F279 S483.20(k) 1. R2 had no adverse effect from this practice. A comprehensive care plan was developed for resident (R2) for actual occurrence and /re-occurrence of pressure ulcers. 2. All residents who have a pressure ulcer and those at a high risk for developing a pressure ulcer. The Director of Nursing will identify other residents through the use of the Braden Scale, skin check assessments to develop comprehensive care plans for residents at risk for pressure ulcers. 3. Licensed nursing staff will be educated on how to develop a comprehensive care plans for residents with or at risk of developing pressure ulcers. The DON/designee will review all residentswho have actual/reoccurring pressures at weekly IDT meeting to ensure appropriate comprehensive care plans have been developed and/or updated. 4. The DON or designee will audit weekly for 4 weeks residents with or at risk of pressure ulcers for care plan development. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

Provider's Signature ______________________ Title ______________________ Date ______________________

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	Clinical record review revealed that R2 was admitted on 1/15/15. 3/24/16 -The facility initiated a care plan entitled, "Potential for alteration in skin Integrity related to: Incontinence, decreased mobility ," Bollus Pemphigoid "(large fluid filled blisters on skin). The approaches were: Encourage and assist with her frequent repositioning; Incontinence care as needed; Apply barrier cream after each incontinence episode; Keep skin clean and dry; Apply lotions or creams to dry skin as needed; Skin checks every shift with care; Total lift with 2 person assist for all transfers; Dermatology appointment as ordered. 11/14/16 The Stage 2 coccyx pressure ulcer was resolved/healed. 12/15/16 and 12/26/16 -The stage 2 coccyx was present. In an interview with E2 (DON) on 12/29/16 at 3:15 PM, she stated that R2's coccyx pressure ulcer comes and goes and confirmed that there was no care plan developed to identify and address the actual occurrences of this pressure ulcer. The facility failed to develop a care plan to address R2's Stage 2 coccyx pressure ulcer. **F280** **§483.20(k)(2) A comprehensive care plan must be--** **(i) Developed within 7 days after the completion of the comprehensive assessment;** **(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines**	F280 S483.20(k)(2) 1. A. R2 and R3 were not adversely affected by this practice. DON/designee reassessed R2 and R3 urine incontinence status and developed a comprehensive care plan to address the residents' needs. B. R4 was not adversely affected by this practice. DON/designee will review resident's comprehensive care plan to

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	as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and **(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.** **This requirement is not met as evidenced by:** Based on record reviews and interviews, it was determined that for 3 (R2, R3 and R4) out of 4 sampled residents, the facility failed to review and revise their care plans. For R2, the facility failed to revise her care plan and individualize her urinary incontinence care based on her toileting needs. For R3, the facility failed to individualize the urinary incontinence care plan and failed to review and revise the care plan based on his toileting needs. For R4, a resident at high risk for falls, the facility failed to have a specific intervention for fall mats on R4's fall care plan. Findings include: 1. Clinical record review revealed that R2 was admitted on 1/15/15 with a diagnosis of an overactive bladder and was receiving a medication to help control her bladder function. R2's monthly Nursing Summary assessments, Quarterly Data Collection Tool assessments and CNA's Resident Monthly Personal Care Record Flow Sheet showed a progressive declined in her bladder urinary function from occasionally incontinent to frequently incontinent and totally incontinent. 3/26/15-The facility developed R2's care plan on "Incontinent of Bladder...related to chronic c-diff., declined mobility, IDDM". The approaches were "Check her frequently and	evaluate the appropriateness of the interventions and monitor the interventions are in place. 2. A. All residents who are incontinent of urine are at risk for this practice. The DON/designee will review all care plans for residents who are incontinent of urine to ensure that the care plans are comprehensive and reflect the residents' urinary incontinence needs. B. All residents who are a high risk for falls are at risk for this practice. The DON/designee will review care plans for all residents assessed at a high risk for falls to ensure that the care plans are comprehensive and that interventions are appropriate and in place. 3. A. Residents who are incontinent of urine will be reviewed monthly to identify their needs and care planned to reflect those needs by the DON/designee. Licensed nursing staff will be in-serviced by DON/designee on updating care plans to reflect the residents' current needs. B. Residents' who are at high risk for falls will have care plans reviewed to ensure comprehensive care plans reflect residents current status. Licensed nursing staff will be in-serviced on updating comprehensive care plans for residents at risk for falls. 4. A.The DON or designee will audit weekly for 4 weeks residents with or at risk of urinary incontinence for comprehensive care plan development. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. B. The DON or designee will audit weekly for 4 weeks residents with or at risk of falls for comprehensive care plan development. Audit results will be reported to our QAPI

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	change as needed; provide pericare after each incontinence episode; apply barrier cream after each incontinence episodes; observe for any redness or skin breakdown during care; observe for s/s of dehydration ex;[example] poor skin turgor; offer fluids frequently; offer use of bedpan. The goal of the care plan stated, "will not exhibit any issues with skin or health R/T incontinence. Although the facility had identified R2's decline in urinary continence, due to lack of appropriate assessment such as the 3 day voiding diary, the facility failed to individualize her care plan by developing a toileting schedule to meet her needs. The facility also failed to take into account the individual findings of the assessments and assistive devices that could potentially restrict or facilitate resident's toileting ability and develop an appropriate plan of action that would meet her toileting needs. This finding was confirmed with E1 (Executive Director/NHA), and E2 (DON) on 1/3/17 at approximately 1:45 PM during the exit conference. **2.** R3 was admitted to the facility on 4/22/16. The admission Data Collection Tool, dated 4/22/16, stated R3 was continent of bladder function and dependent upon staff for toilet use. The ADL Flow Record of R3's bladder function from April 22 – 30, 2016 revealed out of 25 shifts, R3 was incontinent for 10 shifts, continent/incontinent for 4 shifts and 11 shifts lacked documentation. On 4/25/16, R3 was care planned for bladder incontinence with approaches that included to "check him frequently and change as needed…resident is not a	Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	candidate for toileting program due to cognitive decline…take him to restroom when he requests". It was unclear how the facility care planned for R3's urinary incontinence without performing a comprehensive assessment to include a 3-day voiding diary to individualize his care plan according to his toileting needs. It was also unclear how the facility stated in R3's care plan approaches that he was not a candidate for toileting program due to cognitive decline but he could request to use the bathroom. The Nursing Summary, dated 5/12/16, stated that R3 was incontinent where he had inadequate control of his bladder and there was no change in bladder continence. For May 2016, the ADL Flow Record revealed out of 93 shifts, R3 was incontinent of bladder for 43 shifts, continent/incontinent for 19 shifts and 14 shifts lacked documentation. R3's urinary incontinence care plan was reviewed on 6/2/16 and 11/16/16. However, the approaches remained the same. During an interview on 12/29/16 at 10:18 AM, E3 (LPN) confirmed the finding. The facility failed to individualize R3's urinary incontinence care plan and failed to review and revise the care plan based on his toileting needs. 3. R4 resides in The Garden (locked dementia unit). Review of incident reports from January 2016 through November 2016 revealed that R4 had 12 falls during	

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	this timeframe. A care plan conference summary, dated 5/4/16 stated R4 had no safety awareness. An incident report, dated 7/16/16, stated that R4 was found on the fall mat in his room. Review of R4's at risk for falls care plan, last reviewed on 11/29/16, listed an intervention for "Fall mat next to bed as needed." Observation of R4's room on 1/3/17 at approximately 9:25 AM revealed a folded fall mat under R4's bed. R4 was not in his room at this time. Review of ADL Flow Records (completed by CNA's) and TARs (completed by nurse's) from August- November 2016 lacked documentation of fall mats for R4. E8 (CNA assigned to R4) was interviewed on 1/3/17 at 9:30 AM and confirmed that CNA's do not document use of fall mats. E9 (LPN assigned to R4) was interviewed on 1/3/17 at 10:25 AM and confirmed that R4's care plan intervention for fall mats as needed was not specific for R4 and he confirmed there was no documentation of fall mats on the TARs. R4 stated that fall mats should be on the CNA Resident Care Card in R4's room, however, when E9 and the surveyor went to R4's room, fall mats were not checked on the Resident Care Card.	

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	Subsequently, E9 updated R4's fall care plan which stated, "mat to floor R (right) side of bed, at bedtime and when resident is in bed" and he updated the CNA Resident Care Card for "mat to floor on right (side)." Findings were reviewed with E2 (DON) during an interview on 1/3/17 at approximately 12 PM. **F281** ***§483.21(b)(3) Comprehensive Care Plans*** **The services provided or arranged by the facility, *as outlined by the comprehensive care plan,* must—** **(i) Meet professional standards of quality.** **This requirement is not met as evidenced by:** Based on observation, interview, and record review, it was determined that the facility failed to ensure that services provided for one (SS4) out of 7 subsampled residents in the medication pass, met professional standards. Findings include: The facility's LTC Facility Pharmacy Services and Procedures Manual, dated 1/1/13, entitled "General Dose Preparation and Medication Administration", stated, "... 4.1.1 Verify each time a medication is administered that it's the correct medication , at the	F281 S483.21(b)(3) 1. SS4 was not adversely affected by this practice. Upon intervention from surveyor resident (SS4) received the full dose of her medication. 2. All residents have the potential to be affected by this practice. The Licensed Nurse was in-serviced immediately on medication administration. 3. Licensed nursing staff will be in-serviced on proper medication administration according to the Facility's LTC Pharmacy Services and Procedures Manual, "General Dose Preparation and Medication Administration." The DON/designee will conduct a medication pass observation on licensed nursing staff and then again yearly 4. The DON or designee will audit weekly for 4 weeks medication pass observation. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	correct dose… 5.9 Observe the resident's consumption of the medication(s)." On 12/29/16 at approximately 8:25 AM, during the medication pass observation in the Healthcare unit, E3 (LPN) crushed 3 medications (Norvasc- used to treat high blood pressure and chest pain, Losartan-used to treat high blood pressure and Aspirin- used to lower the risk of heart attack and stroke) per physician orders for SS4. The medications were mixed with applesauce in a medication cup. E3 gave SS4 a spoonful of the medication/applesauce mixture leaving approximately 1/8- 1/4 teaspoons of the mixture in the cup and began walking away from SS4. The surveyor stopped E3 and asked her to give the remainder of SS4's medication and E3 then administered the rest of SS4's medication. Findings were reviewed with E2 (DON) during an interview on 1/3/17 at approximately 12 PM. The facility failed to administer the correct dosage of SS4's medications and observe the consumption of the ordered doses of medications until the surveyor intervened.	

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	F309 **§483.25 Quality of Care** **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.** **This requirement is not met as evidenced by:** Based on record review, interview and review of facility documentation, it was determined that for one (R3) out of 4 sampled residents, the facility failed to complete neurological assessments after R3 had two falls. Findings include: The facility's Fall Management & Investigation Program, dated 10/15/11, stated, "…Post fall…If head injury present or suspected. The resident will be monitored, including vital signs…Every 15 minutes x 4, then Every 2 hours x 3, then Every shift x 3…" Review of R3's clinical record revealed the following: 1a. On 4/27/16 at 5:10 AM, R3 was leaning forward in his wheelchair and fell in the day room and sustained an abrasion to his forehead. Neurological assessments were initiated according to the facility's policy. Review of the facility's form for Neurological Assessments, dated 4/27/16, revealed incomplete assessments after R3's fall.	F309 S483.25 1. R3 was not adversely affected by this practice. We cannot retroactively correct the deficient practice cited for the resident found to be affected but we can ensure going forward the following. 2. All residents who fall and have a head injury or suspected head injury are at risk for this practice. All falls for the past 3 months requiring neuro checks will be reviewed to identify trends. 3. All resident who have had falls that require neuro checks will be reviewed at morning clinical meeting for accuracy and completeness, DON/designee will in-service licensed nursing staff on the procedure for completing neuro checks. 4. The DON or designee will audit weekly for 4 weeks residents who experienced falls with head injury suspected or present for fall management and neurological assessment completion. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	1b. On 12/22/16 at 5:00 AM, R3 was found on the floor by his recliner in his bedroom and sustained an abrasion to his forehead. Neurological assessments were initiated according to the facility's policy. Review of the facility's form for Neurological Assessments, dated 12/22/16, revealed incomplete assessments after R3's fall. During an interview on 12/29/16 at 10:02 AM, E2 (DON) confirmed the findings. The facility failed to complete neurological assessments for R3 after he fell on 4/27/16 and 12/22/16. F315 **§483.25(d) Urinary Incontinence Based on the resident's comprehensive assessment, the facility must ensure that – §483.25(d) (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.** **This requirement is not met as evidenced by:** Based on record reviews, review of facility documentation and interviews, it was determined that for two (R2 and R3) out of 4 sampled residents. The facility failed to provide appropriate treatment and services to restore as much normal bladder function as was possible based on their comprehensive assessments. For R2, the facility identified that R2 had a change/decline in continence status, but failed	F315 S483.25(d)(2) 1. Comprehensive urinary incontinence was completed for R2 and R3 and voiding diaries instituted for both. 2. All resident who are incontinent of urine are at risk for this practice. All residents' who are incontinent of urine will have voiding diaries reviewed, any identified as not completed will be re-conducted and assessed for appropriate interventions. 3. Nursing staff will be in-serviced on the facility's Bladder Elimination Assessment policy by DON/designee. DON/designee will review resident's urinary incontinence status quarterly to identify any decline and to put interventions in place. 4. The DON or designee will audit residents weekly for 4 weeks for incontinence assessment and institute voiding diaries as appropriate. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are

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	to reassess her incontinence with a 3-day voiding diary and failed to develop an individualized plan of care based on information from the assessments to meet her toileting needs. The facility failed to comprehensively assess R3's urinary incontinence, failed to complete the 3-day voiding diary, failed to individualize R3's urinary incontinence care plan and failed to reassess when he was identified as incontinent. Findings include: The facility's policy entitled "Bladder Elimination Assessment", last reviewed on 8/5/16, stated, "…Each resident will be assessed on admission to determine bladder continence or incontinence. If it is determined that the resident is incontinent an in-depth assessment will be completed using the Bladder Incontinence Evaluation Form. The resident will be re-assessed if there is a significant status change and annually. A 3-day bowel and bladder flow sheet will be completed on each incontinent resident. Utilizing the Evaluation Form and the Flow Sheet, the recommendation will be made for a Retraining Program if appropriate for the resident…" "If resident is determined to be incontinent on the Admission Nursing Assessment, the nurse will gather more specific information by completing the Bladder Incontinence Assessment...and begin a 3-day...Bladder Flow Sheet. This assessment will identify patterns of incontinent episodes; ...Contributing factors/diagnosis (such as medical diagnosis) that may affect urinary continence; use of medications that might impede or affect the ability to maintain continence; ...environmental factors and assistive devices that restrict or facilitate resident's toileting ability... If the resident is not a candidate for a re-training program (or refuses to participate in the program), care planning for the resident	established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	should take into account the individual findings of the assessments". 1. Review of R2's clinical record revealed the following: 1/15/15 -R2 was admitted to the facility at 11:45 AM with a history of an over active bladder. 1/15/15- The facility's admission Data Collection Tool assessment stated that R2's cognitive skills for decision-making were independent (consistent/reasonable) was continent of bladder, totally dependent on staff for toileting use, able to weight bear, used a sit to stand mechanical lift for transfers and the wheelchair only for ambulation. Despite R2's admission Data Collection Tool stating she was continent, review of R2's January 2015 CNA's Resident Monthly Personal Care Record Flow Sheet revealed that she was both continent and incontinent of urine. 2/19/15- The monthly nursing summary assessment stated that R2 was occasionally incontinent of bladder (2 or more times a week). The facility failed to reassess R2's urinary incontinence to include use of a 3-day voiding diary. 3/11/15- A quarterly Data Collection Tool assessment stated that R2 was continent of bladder with some incontinent episodes and the devices used were pads/briefs and bedpan. 3/26/15-The facility developed R2's care plan on "Incontinent of Bladder...R/T chronic c-diff., declined mobility, IDDM". The approaches were "Check her frequently and change as needed; provide pericare after each incontinence episode; apply barrier cream after each incontinence episodes; observe for any redness or skin breakdown during care;	

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	observe for s/s of dehydration ex [example]; poor skin turgor; offer fluids frequently; offer use of bedpan. The goal of the care plan stated, "will not exhibit any issues with skin or health R/T incontinence. The care plan approaches did not include an individualized toileting schedule based on a 3-day voiding diary. 4/11/15 - A monthly Nursing Summary assessment stated that R2 was frequently incontinent of bladder and again, there was lack of documentation that a 3-day voiding diary assessment was done. 5/04/15 - R2 was prescribed a medication to treat her symptoms of overactive bladder to control the frequency of urination. Despite this treatment, the facility lacked documentation that a 3 day voiding diary was initiated to determine R2's incontinence pattern. 5/14/15, 6/18/15, 8/11/15, 9/11/15, 10/12/15 quarterly and monthly assessments and CNAs ADL flowsheets of 11/16 and 12/16 documented that R2 was totally incontinent of bladder. 12/29/16 at approximately 9:00 AM, in an interview with R2, she stated that when she was out of bed in her wheelchair attending activities and staying for lunch after the activities, she wets her adult pad, her pad was changed later when she returned to her room. R2 stated it varies depending on who was assigned to care for her. 12/29/16 at 10:15 AM, in an interview with E3 (LPN), she confirmed that staff did not use a 3 day voiding diary to determine R2's voiding pattern. At about this time, E2 (DON) also confirmed that R2 did not have a 3-day voiding diary assessment record initiated. 12/29/16 at 10:50 AM, it was observed that when R2 was turned on her side by E5 and E15 (CNAs) and her adult pad was removed, R2's pad and buttocks and surrounding area	

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	was very wet and buttocks were very red. It was unknown as to what time her pad was last changed. 1/3/17 at 8:50 AM, during an interview with E14 (CNA), she stated that she changed R2's adult pad upon waking up, before breakfast, before lunch and after lunch on her shift (7-3 PM). She was not sure what other CNAs did on their shifts. 12/29/16 -Review of CNAs ADL Flow Record documentation of her bladder function care for 12/16 revealed that on the evening shift 10 out of 28 days, lacked documentation that care was provided and also 6 days on the night shift. E2 (DON) confirmed this finding with the surveyor. The facility failed to initiate a 3-day voiding diary to determine R2's incontinent pattern and if R2 was a candidate for an individualized scheduled toileting program (or refuses to participate in the program). Although the facility had identified R2's decline in urinary bladder, they failed to re-assess determine her incontinent pattern and failed to adjust her care plan to meet her toileting needs. This finding was confirmed with E1 (Executive Director/NHA), and E2 (DON) on 1/3/17 at approximately 1:45 PM during the exit conference. 2. R3 was admitted to the facility on 4/22/16 with diagnoses including dementia and history of prostate cancer. The admission Data Collection Tool [DCT], dated 4/22/16, stated R3 was continent of bladder function and dependent upon staff for toilet use. The ADL Flow Record of R3's bladder function from April 22 – 30, 2016 revealed out of 25 shifts, R3 was incontinent for 10	

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	shifts, continent/incontinent for 4 shifts and 11 shifts lacked documentation. On 4/25/16, R3 was care planned for bladder Incontinence with approaches that included to "check him frequently and change as needed…resident is not a candidate for toileting program due to cognitive decline…take (sic) him to restroom when he requests". It was unclear how the facility care planned for R3's urinary incontinence without performing a comprehensive assessment to include a 3-day voiding diary and individualized his care plan according to his toileting needs. For May 2016, the ADL Flow Record revealed out of 93 shifts, R3 was incontinent of bladder for 43 shifts, continent/incontinent for 19 shifts and 14 shifts lacked documentation. The 5/12/16 Nursing Summary which reflected the status of R3's last 30 days stated that R3 was incontinent where he had inadequate control of his bladder and there was no change in bladder continence. It was unclear how the facility assessed R3 with inadequate control of his bladder when the ADL Flow Record stated that he was continent of bladder at times. The facility failed to reassess R3's urinary incontinence. On 6/2/16, R3's urinary incontinence care plan was reviewed and the approaches remained the same. For June 2016, the ADL Flow Record revealed out of 90 shifts, R3 was incontinent for 46 shifts, continent/incontinent for 15 shifts and 29 shifts lacked documentation.	

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	For July 2016, the ADL Flow Record revealed out of 93 shifts, R3 was incontinent for 57 shifts, continent/incontinent for 26 shifts and 10 shifts lacked documentation. The Nursing Summary, dated 7/12/16, stated that R3 was incontinent where he had inadequate control of his bladder despite the ADL Flow Record stating he was continent at times. For August 2016, the ADL Flow Record revealed out of 93 shifts, R3 was incontinent for 46 shifts, continent/incontinent for 37 shifts and 10 shifts lacked documentation. The Nursing Summary, dated 8/12/16, stated that R3 was incontinent where he had inadequate control of his bladder despite the ADL Flow Record stating he was continent at times. For September 2016, the ADL Flow Record revealed out of 90 shifts, R3 was incontinent for 48 shifts, continent/incontinent for 29 shifts and 13 shifts lacked documentation. The quarterly Data Collection Tool [DCT] form, dated 9/14/16, stated R3 was incontinent of bladder. The DCT form also stated when incontinent was checked the required Bowel and Bladder forms were to be completed. The facility lacked evidence that R3 was reassessed and the facility's forms were completed according to their policy. For October 2016, the ADL Flow Record revealed out of 93 shifts, R3 was incontinent for 60 shifts,	

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	continent/incontinent for 25 shifts and 8 shifts lacked documentation. The Nursing Summary, dated 10/13/16, stated that R3 was incontinent where he had inadequate control of his bladder despite the ADL Flow Record stating that he was continent at times. For November 2016, the ADL Flow Record revealed out of 90 shifts, R3 was incontinent for 41 shifts, continent/incontinent for 42 shifts and 7 shifts lacked documentation. The Data Collection Tool form, dated 11/12/16, stated R3 was incontinent of bladder. The facility lacked evidence that R3 was reassessed. On 11/16/16, R3's urinary incontinence care plan was reviewed and the approaches remained the same. For December 1-27, 2016, the ADL Flow Record revealed out of 81 shifts, R3 was incontinent for 37 shifts, continent/incontinent for 21 shifts and 23 shifts lacked documentation. The quarterly Data Collection Tool form, dated 12/20/16, stated R3 was incontinent of bladder. The facility lacked evidence that R3 was reassessed. During an interview on 12/29/16 at 10:18 AM, E3 (LPN) stated that the facility does not use a 3-day voiding diary. E3 also stated that the Bowel and Bladder forms identified on the DCT form are not used when incontinence was identified. Findings were confirmed with E3 during this interview. The facility failed to comprehensively assess R3's urinary	

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	incontinence, failed to complete the 3-day voiding diary, failed to individualize and revise R3's urinary incontinence care plan and failed to reassess his urinary incontinence when he was identified as incontinent.	
	F323 **§483.25(h) Accidents** **The facility must ensure that –** **(1) The resident environment remains as free from accident hazards as is possible; and** **(2) Each resident receives adequate supervision and assistance devices to prevent accidents.** **This requirement is not met as evidenced by:** Based on record review, interview and review of facility documentation, it was determined that for two (R1 and R3) out of 4 sampled residents, the facility failed to ensure that these residents remained free from accident hazards, received adequate supervision and assistive devices. For R3 the facility failed to ensure R3's chair alarm was in place and functioning. For R1 the facility failed to adequately supervise R1 during the provision of care. Findings include: 1. The facility's Fall Management & Investigation Program, dated 10/15/11, stated , "To utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assistive devices and interventions to manage and minimize falls and identify resident's continued needs...". Review of the clinical record for R3	F323 S483.25(h)(1)(2) 1. A. R1 no longer resides in the facility. B. R3's chair alarm was immediately fixed and staff inserviced on the importance of supervision for lack of safety awareness in the dining room. 2. A. All residents who are dependent for ADL care in bed are at risk for this practice. All residents who are dependent for ADL care in bed will be evaluated by rehab to determine the level of care and assistance needed by caregivers. B. All residents who have chair alarms have the potential to be affected by the practice. Resident with alarms will have them checked for functionality and will be checked every shift by nursing 3. A. Nursing staff will be in-serviced by DON/designee on the requirements of residents who are dependent for ADL's while in bed. B. Licensed nurses will be in-serviced by DON/designee on checking chair alarm placement and functionality every shift. 4. The DON or designee will audit residents who fall immediately to assess appropriate interventions. Falls statistics will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	revealed the following: R3 was admitted to the facility on 4/22/16 with diagnoses of dementia and history of falls. Upon admission on 4/22/16, R3 was identified as a high risk for falls according to the facility's Fall Review form, which stated he had a history of falls in the last 6 months, impaired mental status, poor safety awareness and impaired mobility. On 4/25/16, R3 was care planned for at risk for falls with an approach that included a chair alarm. In addition, R3 was care planned for at risk for personal injury related to lack of safety awareness due to dementia with an approach that included providing supervision with all activities. The facility's Incident Report, dated 11/14/16, stated that R3 was found on the dining room floor by E5 (CNA) at 10:35 AM. According to E5's statement, she moved R3's wheelchair to a table allowing another staff member and resident to pass. E5 left the dining room to help another resident for less than 2 minutes. E5 returned and found R3 on the floor. R3 sustained a skin tear to his right elbow. The facility's response after the fall was placement of a chair alarm and to check functionality. In an interview on 12/29/16 at 10:02 AM, E3 (LPN) confirmed that the chair alarm was not in place at the time of R3's fall on 11/14/16 in the dining room. Findings were reviewed with E2 (DON) on 12/29/16 at 3:40 PM. The facility failed to ensure that R3's chair alarm was in place	

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	and functioning and failed to provide adequate supervision according to his plan of care. 2. Review of the clinical record for R1 revealed R1 had diagnoses that included advanced dementia and heart disease and R1 was receiving end of life care via Hospice services. A care plan for the problem "Total assist with ADL's," last reviewed 12/3/15, included the intervention "two (2) person's present for care as needed." A care plan for the problem "At risk for fall related to poor safety awareness and dementia," last reviewed 12/10/15, included the interventions "provide bed in lowest position; provide bed and chair alarms; and fall mat next to bed as needed." The facility's Incident Report Form, dated 1/7/16 and timed 10:45 PM, stated "R1 fell from the bed to the floor sustained laceration on L (left) forehead, skin tear L hand middle finger and both knees." The facility's Investigation Report: Staff Interview," dated 1/7/16 and completed by E6 (CNA assigned to R1 on 3-11 PM shift on 1/7/16), stated "As I was doing my last round changes on (name of R1) I rolled her on her side, she fell on the floor." An Interdisciplinary Progress Note, dated 1/7/16 and timed 12:00 AM, stated "At 10:45 PM resident fell from bed to the floor while being given care by CNA. Sustained laceration on L (left) forehead, skin tear L middle finger and both knee (sic)...sent out to hospital for	

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	evaluation…" Record review revealed the resident was sent out to the hospital post fall for evaluation, as R1 was receiving blood thinning medication. An additional statement, dated 1/12/16, included on the above mentioned Investigation Report, stated "Phone conversation. When questioned, (E6) stated she turned resident to clean her buttock and moved her brief when she suddenly rolled off of the bed on to the floor." The ER Physician Record, dated 1/8/16 and timed 1:51 AM, stated "…sustained a wound to her left forehead…laceration above the left eyebrow, superficial, no active bleeding…1/8/16 3:44 AM…wound was closed using wound glue…1/8/16 7:35 AM…CT scan was limited due to movement but there was no gross evidence of bleeding…x-rays of the hand do not show any acute fracture…". The hospital record review revealed R1 was admitted to the inpatient Hospice unit and expired on 1/11/16. The Certificate of Death listed end stage heart disease as the immediate cause of death. The facility failed to ensure that R1 did not have an avoidable fall during the provision of care that resulted in injuries. The findings were reviewed with E2 (DON) during an interview on 1/3/17 at approximately 11:00 AM. E2 confirmed the fall "should not have happened."	

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	F329 **§483.*45(d)* Unnecessary Drugs—General.** **Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-** ***(1)* In excessive dose (including duplicate *drug* therapy); or** ***(2)* For excessive duration; or** ***(3)* Without adequate monitoring; or** ***(4)* Without adequate indications for its use; or** ***(5)* In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or** **(6) Any combinations of the reasons stated *in paragraphs (d)(1) through (5) of this section.*** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that the facility failed to provide adequate monitoring of one (R4) out of 4 sampled resident's drug regimens. The facility failed to consistently monitor R4's behavior(s), interventions and the effectiveness of the medication Trazadone used prn for anxiety. Findings include: R4 was admitted to the facility in December 2015 and resides in The	F329 S483.45(d)(1)through(5) 1. R4 was not adversely affected by this practice. We cannot retroactively correct the practice for this resident 2. All residents receiving PRN psychotropic medication are at risk for this practice. All residents receiving PRN psychotropics will be reviewed to identify any missed opportunities to address resident behaviors. 3. Licensed nursing staff will be educated on proper interventions and documentation needed before anti-psychotic medication is administered. 4. The DON or designee will audit all residents on anti-psychotic medications weekly for 4 weeks to ensure behavior forms and documentation is correct. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes

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	Garden, a locked dementia unit. Review of R4's Behavior/Intervention Monthly Flow records from August-November 2016 identified yelling, screaming, kicking, hitting and pushing as specific behaviors that may require the use of prn Trazadone. When behaviors are identified, there are codes for non-pharmacologic interventions including redirection, 1:1 (one to one time with resident), refer to NN's, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature and back rub. There is also a code for medication which states, "should not be first intervention." Additionally, the number of times a behavior occurs per shift is to be recorded on these records. Review of R4's MARs, NN's, and Behavior/Intervention Records from August- November 2016 were reviewed and revealed that Trazadone prn was administered as follows: 8/10- lacked non-pharmacologic interventions; 8/12- lacked behaviors (only listed anxiety which is the reason Trazadone was given, not a specific behavior) and effectiveness of Trazadone; 8/24- lacked number of behavior episodes, behavior(s) and non-pharmacologic interventions; 10/6- lacked number of behavior episodes, behavior(s) and non-	

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	pharmacologic interventions; 10/8- lacked number of behavior episodes for 9 PM Trazadone; 10/9- lacked number of behavior episodes, behavior(s) for 8 PM Trazadone; 10/13, 10/31, 11/12- lacked number of behavior episodes, behavior(s) and non-pharmacologic interventions. Findings were reviewed with E2 (DON) during an interview on 1/3/17 at approximately 12 PM. **F333** **§483.*45(f)* Medication Errors.** **The facility must ensure that *its*—** **§483.*45(f)* (2) Residents are free of any significant medication errors.** **This requirement is not met as evidenced by:** Based on clinical record reviews and interviews, it was determined that the facility failed to ensure that 2 (R1 and R4) out of four (4) sampled residents were free of any significant medication errors. Findings include: The facility policy titled "Medication And Treatment Order Guidelines," dated 3/4/04, stated "…3.0 PROCEDURE 1. The licensed nurse is responsible for clarification of all orders that may lead to an error: illegible orders; incomplete	F333 S483.45(f)(2) 1. We cannot retroactively correct the deficient practice citied for R4. R1 no longer resides in the facility. 2. All residents on the medication Coumadin have potential to be affected by this deficient practice. 3. Staff will be educated on the medication transcription process. Nurses will also have a 2 person check order for all Coumadin orders. 4. DON or designee will audit weekly for 4 weeks all residents who have orders for Coumadin to ensure orders are transcribed correctly. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	orders; contradictory orders related to dosage changes…2. The licensed nurse will contact the resident's health practitioner to verify/confirm any order that is unclear. New orders involving changes in dose, strength and/or time should be compared with the previous order for appropriateness/accuracy…" 1. The clinical record revealed R1 had a mechanical heart valve and was receiving Coumadin to prevent the formation of clots. A care plan, reviewed on 9/10/15 and 12/4/15, for the problem "Resident at risk for abnormal bleeding secondary anticoagulant use Coumadin," included the interventions to administer medications as ordered, monitor labs as ordered, and Coumadin adjusted based on laboratory work. Review of R1's clinical record revealed the following: 10/6/15 – A laboratory blood test result revealed the INR was 3.57 (the desired therapeutic range was 2.50 to 3.50). A physician's order was written to hold Coumadin tonight then resume Coumadin 6 mg daily at bedtime. 10/10/15 - Review of the MAR lacked evidence that the Coumadin 6 mg dose ordered was administered (no signature signifying it was given). 10/22/15 - A laboratory blood test result revealed the INR was 1.73. The	

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	laboratory sheet had a notation on it stating, "Change Coumadin to 5 mg Q HS." Although the facility changed the Coumadin order on the October 2015 MAR, they failed to write a corresponding order on a physician's order sheet. 10/27/15 – Physician's order written to increase Coumadin to 6 mg daily at bedtime. 11/3/15 - Review of the MAR lacked evidence that the Coumadin 6 mg dose ordered was administered (no signature signifying it was given). 12/18/15 - A laboratory blood test result revealed the INR was 1.86. A physician's order was written to increase Coumadin to 5.5 mg daily. 12/26/15 – The monthly recapitulation of physician's orders was completed. During this recapitulation of orders the facility failed to cross off and mark as discontinued two (2) Coumadin orders which were not in effect. Additionally, there was an order handwritten in for Coumadin 5.5 mg daily every evening with no start date noted. 12/26/15 – A laboratory blood test result revealed the INR was 4.10. A physician's order was written to hold Coumadin 12/26 and 12/27 and recheck INR on Monday, 12/28/15. 12/28/15 – There was no evidence that an INR was drawn. However, a nurse's progress note stated the physician was	

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	called and ordered for R1 to receive Coumadin 5 mg at bedtime. 12/29/15 – A laboratory blood test result revealed the INR was 1.94. A physician's order was written "Restart Coumadin 4.0 mg by mouth daily." There was no evidence in the clinical record that the facility verified/clarified this order as on 12/28/15 Coumadin 5 mg had been ordered and the INR was at a sub therapeutic value. 12/29/15 through 12/31/15 – Review of the MAR revealed that Coumadin 4 mg was administered every evening. Review of physician's order sheets revealed there were no order changes to the Coumadin dosage during this time frame. 1/1/16 through 1/7/16 – review of the MAR revealed that Coumadin 5.5 mg was administered in error for a total of six (6) doses. It was noted on the MAR that R1 spit out the evening medications on 1/4/16. The most recent Coumadin order change was on 12/29/15 for 4 mg to be administered every evening. The facility failed to administer Coumadin according to physician's orders resulting in a significant medication error. 1/2/16 - A laboratory blood test result revealed the INR was 2.09. A notation on the laboratory sheet noted the NP was notified and to continue the same dose of Coumadin. 1/5/16 – A laboratory blood test result revealed the INR was 3.29. The physician	

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	was called with the results and there were no new orders given. 1/7/16 – R1 was sent out to the hospital for evaluation after a fall from bed. 1/8/16 3:04 AM – Hospital laboratory results revealed R1's INR was 8.9, more than twice the desired range. The facility failed to ensure that Coumadin was administered according to physician's orders. 1/3/17 approximately 11:00 AM – During an interview the findings were reviewed and confirmed by E2 (DON). E2 stated that after the monthly recap was completed on 12/26/15, the facility failed to go back and correct the January, 2016 MAR when new orders were written on 12/29/15. E2 also stated that she cannot state whether the doses of Coumadin were given or not on 10/10/15 and 11/3/15. 2. Review of physician orders from R4's cardiologist revealed an order dated 10/18/16 for Coumadin to be held on 10/19/16 and to resume taking one tablet (5 mg.) daily on 10/20/16. Review of the October 2016 MAR revealed that the facility wrote "hold" for the 10/20/16 dose of Coumadin 5 mg. indicating that the Coumadin was incorrectly held instead of being resumed as ordered. Findings were reviewed and confirmed	

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	with E2 (DON) during an interview on 1/3/17 at approximately 12 PM.	
	F371 **§483.35(i)(2) The facility must store, prepare, distribute and serve food under sanitary conditions** **This requirement is not met as evidenced by:** Based on observations, record review and interview, the facility failed to properly store and label opened foods, prepare food and hold cooked foods under safe and sanitary conditions, monitor refrigerator temperatures daily, ensure proper hand washing, and protect food contact surfaces from contamination to prevent foodborne illness. Findings include: Observations made during the tour of the kitchen on 12/27/16 from 8:20 until 8:45 AM revealed the following: 1) An opened package of liverwurst in the large walk-in refrigerator was wrapped with no label; 2) An opened package of shredded cheese in the large walk-in refrigerator was wrapped with no label; 3) A bowl of tuna fish in Unit #6 refrigerator was stored on the glass shelf at the bottom of the refrigerator, uncovered and unlabeled. 4) Three (3) medium-sized covered bins containing thickener, brown rice, and sugar had powdery material on top of the lids. The bin with thickener also had a scoop inside with the thickener. The same bin was again observed with a scoop inside on 1/3/17 at 9	F371 S483.35(i)(2) 1. Upon findings from surveyor all food in the refrigerator and dry storage room were labeled and dated or discarded. 2. All residents have the potential to be affected by the deficient practice. 3. Dinning Services staff will be educated on labeling and dating all food in refrigerators and the dry storage room according to the facility policy. 4. The Dining Services Manager or designee will audit weekly for 4 weeks refrigerator and dry storage room for labeling and dating of all food inventory. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 1. The ice machine was immediately cleaned. The ice machine is cleaned and serviced quarterly by a contracted company. 2. All residents have the potential to be affected by the deficient practice. 3. Staff will be educated to contact the 3rd party company if service/cleaning is required earlier than quarterly. 4. The Dining Services Manager will audit the ice machine for black specks weekly for 4 weeks. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	AM. 5) The ice machine had several black specks on the surface of a cream-colored panel at the back end inside of the machine. 6) Three kitchen staff, E16, E17, and E18 performed handwashing at least once between 8:20 and 8:45 AM. After handwashing, staff dried their hands with a paper towel and discarded the paper towel in a covered garbage container, touching the lid in the process, recontaminating their hands. E18 touched a cart, a rack, a paper towel from the paper towel dispenser, and handled newly washed dishes and plate domes. 7) On 1/3/17 at 8:10 AM, E19, was observed slicing bread with his bare hands. Prior handwashing was not observed. 8) Two (2) cold beverage dispensers with clusters of dust and syrupy stains behind the nozzles, as well as syrup spillage collecting at the base of one of the dispensers, were observed on 12/27/16 at 8:40 AM and again on 1/3/17 at 9:35 AM. Interview with E20 (FSD) revealed the dispensers were serviced once a month by a beverage vendor. Inspection of the dry food storage area on 12/28/16 at 12:08 PM revealed the following observations: 1) An opened box of 2 lb. Baker Source cane sugar was wrapped with no label; 2) A box of Belgian waffle mix was opened, unwrapped and unlabeled; 3) An opened box of French's Crispy Fried Onions was wrapped and labeled with 'Use by Date' of 11/21/16. Observations made during inspection of the Healthcare dining room on 12/28/16 at 8:38 AM revealed: 1) A refrigerator located in a small room	1. The dining services staff observed not utilizing proper hand sanitation techniques were immediately educated on the proper hand sanitation procedure. 2. All residents have the potential to be affected by the deficient practice. 3. Dining Services staff will be educated on proper hand washing procedures 4. The Dining Services Manager will audit hand washing techniques weekly for 4 weeks. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 1. The cold beverage dispensers found dusty and with syrupy stains were cleaned by a 3rd party vendor. 2. All residents have the potential to be affected by the deficient practice. 3. The 3rd party vendor has agreed to service/clean beverage dispensers on a monthly basis. 4. The Dining Services Manager will audit beverage station to ensure monthly cleaning is being completed by vendor and/or more frequency is needed. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 1. The refrigerator in the small dining room was cleaned and the temperature log updated. 2. All residents have the potential to be affected by the deficient practice. 3. Staff was educated on proper cleaning and temperature log recording daily.

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	adjacent to the dining room had stains and dirt on the glass cover and the two crispers below; the right crisper also had pinkish spillage concentrated on the front end of the crisper. 2) The temperature log on the refrigerator door was missing temperatures for November 26-30, 2016 and December 25, 2016 (observed on 12/28/16), and December 27-31, 2016 (observed on 1/3/17 at 9:40 AM with E20). During an interview on 1/3/17 at 9:40 AM, E20 stated that Nursing was responsible for the monitoring of the refrigerator temperatures while Food Service was responsible for the cleaning. 3) During lunch observations on 12/28/16 at 12:15 PM, platters of cheese sandwiches, cooked vegetables, cheddar mashed potatoes, garlic bread, and cabbage rolls, and a bowl of gravy were found on a table in a room next to the dining room. Each container had a plastic wrap cover that was pulled back during meal service to plate for the residents. The plastic wrap was not placed back over the dishes after the service, leaving the foods exposed and unprotected from contamination for at least 25 minutes.	4. The Dining Services Manager or designee will audit weekly for 4 weeks the cleanliness and temperature recording of the dining room refrigerator. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes. 1. Staff was educated on leaving food exposed and unprotected from contamination. 2. All residents have the potential to be affected by the deficient practice. 3. Dining Services Manager or designee will ensure staff is following proper protocol to prevent food contamination. 4. The Dining Services Manager will audit dining room for food contamination weekly for 4 weeks. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.
	F431 **§483.*45(g)* Labeling of Drugs and Biologicals** **Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration**	F431 S483.45(g) 1. Resident SS1 was not affected by the deficient practice cited. 2. All residents have the potential to be affected by the deficient practice cited. 3. DON or designee will educate staff on proper removal of expired medications according to the pharmacy policy manual. Staff will also be educated on the recording of medication refrigerator temperatures. 4. DON or designee will audit weekly for 4 weeks all medication carts for expired

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	date when applicable. **§483.*45*(*h*) Storage of Drugs and Biologicals. F431** **(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.** **This requirement is not met as evidenced by:** Based on observations, review of the facility's documentation and interviews, it was determined that for two out of two medication refrigerators, the facility failed to monitor for proper temperature controls daily. In addition, the facility failed to ensure expired medications for SS1 were identified and removed from potential use in one out of two medication carts reviewed. Findings include: The facility's policy "Medication Management Guidelines", last reviewed on 8/5/16, stated, "…3.2 Drug Storage…4. Store drugs…No discontinued, outdated or deteriorated drugs may be retained for use…6. Monitor storage temperatures. Check refrigerator temperatures daily to ensure the temperature range is maintained…". 1. Review of the Garden unit's medication refrigerator temperature log on 12/28/16 at 9:37 AM revealed the following 20 dates with missing temperatures: 4/28/16, 4/29/16, 4/30/16, 5/1/16, 7/27/16, 7/28/16, 7/29/16, 7/31/16, 8/13/16, 8/19/16, 10/27/16, 11/3/16, 11/7/16, 11/8/16, 11/9/16, 11/14/16, 11/15/16, 11/16/16,	medications and also medication refrigerator temperatures. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	11/25/16 and 12/27/16. During an interview on 12/28/16 at 9:39 AM, E4 (LPN) confirmed the finding. Review of the Healthcare unit's medication refrigerator temperature log on 12/28/16 at 10:21 AM revealed the following 15 dates with missing temperatures: 1/30/16, 1/31/16, 2/13/16, 2/14/16, 2/24/16, 2/27/16, 2/28/16, 3/9/16, 3/10/16, 3/11/16, 3/12/16, 3/13/16, 3/18/16, 7/31/16 and 12/27/16. During an interview on 12/28/16 at 10:23 AM, E3 (LPN) confirmed the finding. The facility failed to monitor for proper temperature controls daily for two out of two medication refrigerators. 2. An observation of the healthcare medication cart on 12/28/16 at 10:12 AM revealed 3 (three) blister packs that contained 30 Acetaminophen tablets per pack, totaling 90 tablets, with an expiration date of 9/30/16 prescribed for SS1. During an interview on 12/28/16 at 10:13 AM, E3 (LPN) immediately confirmed the finding and removed the medication. The facility failed to ensure that expired medications were identified and removed from the medication cart. **F441** **§483.65(b) Preventing Spread of Infection** **§483.*80* Infection Control** **The facility must establish and maintain an infection *prevention and***	F441 S483.65(b) S483.80 1. A. SS6 and SS7 no longer reside at the facility. B. We cannot retroactively correct the deficient practice for SS5. 2. A. All residents have the potential to be

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	control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of *communicable* diseases and infections. **§483.*80(a)* Infection *prevention and* control program.** **The facility must establish an infection *prevention and* control program *(IPCP) that must include, at a minimum, the following elements:*** ***(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;*** ***(2) (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.*** **This requirement is not met as evidenced by:** Based on observation, record review and interview, it was determined that the facility failed to maintain an infection prevention and control program in order to prevent the transmission of communicable diseases and infection	affected by this practice. E4 was immediately in-serviced on policy and procedure of medication administration. b. All residents getting blood sugar testing have the potential to be affected by this practice. E3 was immediately in-service on blood sugar testing 3. A. Licensed nursing staff will be in-serviced on proper infection control techniques when administering medications. B. Licensed nursing staff will be in-serviced on proper infection control techniques when testing blood sugar. 4. DON or designee will audit weekly for 4 weeks LPN's hand hygiene while administering medications during med pass. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	during the medication pass. The facility also failed to ensure that nursing staff performed hand hygiene after fingerstick blood sampling. Findings include: The facility procedure "Bubble Pack Medication Administration", dated 12/1/10, stated, "... 4.4... In the event that a medication is dropped... a replacement dose will be taken from the last date on the card..." The facility procedure "General Dose Preparation and Medication Administration", dated 1/1/13, from the LTC Facility Pharmacy Services and Procedures Manual, stated, "... 3.4 Facility staff should not touch the medication when opening a bottle or unit dose package...". E4 (LPN) was observed during the medication pass on 12/29/16 in The Garden (locked dementia unit): 1A. At 8:50 AM, E4 dropped SS5's Paxil (used to treat depression) onto the top of the medication cart as she popped the medication from the bubble pack (type of unit dose package) it came in. E4 picked the Paxil up with her bare hand and placed it into a medication cup which she then administered to SS5. 1B. At approximately 9:15 AM, E4 handled SS6's Depakote (used to treat seizures and as a mood stabilizer primarily) with her bare hand as she removed one capsule from a bubble pack	

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	that contained three. 2. On 12/28/16 at 11:55 AM, E4 was observed entering the Healthcare dining room and proceeding toward a table where three residents were seated. E4 approached SS7 and told her she needed to do a fingerstick test on her. E4 pierced the resident's finger and collected blood on a test strip to read with a meter she brought with her. After she was done, E4 gave SS7 yogurt, collected her things and left the room. Hand hygiene by E4 was not observed before, during or after the activity. Findings were reviewed and confirmed with E4 on 12/29/16 at approximately 9:50 AM and they were reviewed with E2 (DON) on 1/3/17 at approximately 12PM. **F465** **§483.90(h) Other Environmental Conditions** **The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.** **This requirement is not met as evidenced by:** Based on observation and interview, the facility failed to ensure that ceiling vents near the food production area, and the heating lamp over hot foods were free from dirt to prevent food contamination. Findings include:	F465 S483.90(h) 1. The ceiling vent and retractable cord were immediately cleaned. 2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance Director will clean vents monthly or as needed to ensure cleanliness 4. The Maintenance Director will audit vents and retractable cords weekly for 4 weeks. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	During the kitchen inspection on 12/27/16 from 8:20 AM until 8:45 AM, one ceiling vent over the dishwasher and another ceiling vent above the production area were found to be dusty with clusters of dust being observed at the edges of the grill. In an interview on 1/3/17 at 9:10 AM, E20 (FSD) stated the ceiling vents were cleaned by housekeeping recently. During the same period of observation from 8:20 AM until 8:45 AM on 12/27/16, the retractable cord projecting from the ceiling and on which a rectangular heat lamp over hot foods was mounted, was found to be dusty. **F514** **§483.75(l) Clinical Records** **(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are--** **(i) Complete;** **(ii) Accurately documented;** **(iii) Readily accessible; and** **(iv) Systematically organized.** **This requirement is not met as evidenced by:** Based on record review and interviews, it was determined that for one (R3) out of 4 sampled residents, the facility failed to maintain R3's clinical record in accordance with accepted professional standards and practices that are complete and readily accessible. Findings include: 1A. Review of R3's bladder function in the monthly ADL Flow Records revealed the following:	F514 S483.75(l) 1. We cannot retroactively correct the deficient practice cited for R3. Third party Physical Therapy Company supplied the records upon request of the facility. 2. All residents have the potential to be affected by the deficient practice. 3. Staff will be educated on completing flow records for all residents in a timely and complete manner according to the facility policy. LPN staff will be educated on requesting clinical records from third party providers. 4. DON or designee will audit resident flow records and 3rd party provider clinical records weekly for 4 weeks. Audit results will be reported to our QAPI Committee to review outcomes and make recommendations for improvement. Results thresholds are established at 100%. The frequency of audits will be adjusted according to the outcomes.

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	- April 22-30, 2016 – 11 out of 25 shifts were blank; - May 2016 – 14 out of 93 shifts were blank; - June 2016 – 29 out of 90 shifts were blank; - July 2016 – 10 out of 93 shifts were blank; - August 2016 – 10 out of 93 shifts were blank; - September 2016 – 13 out of 90 shifts were blank; - October 2016 – 8 out of 93 shifts were blank; - November 2016 – 7 out of 90 shifts were blank; and - December 1-27, 2016 – 23 out of 81 shifts were blank. During an interview on 12/29/16 at 10:18 AM, E3 (LPN) confirmed the findings. The facility failed to maintain a complete clinical record of R3's bladder function for approximately 9 months. 1B. R3's clinical record revealed a physician order, dated 4/22/16, for physical therapy. Review of R3's clinical record revealed the absence of physical therapy records as ordered by the physician on 4/22/16. During an interview with E2 (DON) and E3 (LPN) on 1/3/16 at 10:03 AM, E2 (DON) stated that R3 received physical therapy in the facility by a 3rd party. E3 immediately called the 3rd party and requested them to fax R3's physical therapy records to the facility. The facility failed to maintain a complete and readily accessible clinical record for R3.	

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5.0	**Personnel/Administrative**	
5.6	**Dementia Training**	5.6 1. We cannot retroactively correct the deficient practice cited by surveyor. 2. All residents with dementia have the potential to be affected. 3. The Director of Nursing or designee will conduct annual educational training for those healthcare providers. 4. The Director of Nursing will audit education records monthly and bring results to our QAPI meetings to ensure staff Dementia education is up to date.
5.6.1	**Nursing Facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participates in continuing educations programs.**	
5.6.2	**The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.** **This Requirement is not met as evidenced by:** Based on review of facility nursing staff personnel files, facility documentation, and interview, it was determined that the facility failed to ensure that 6 direct health care providers (E3, E10, E11, E12, E13, and E14) out of 6 sampled LPNs, who must participate in continuing education programs, lacked specific dementia training for the last year. Findings include: Review of facility documents revealed that 6 direct health care providers (E3, E10, E11, E12, E13, and E14) out of 6 sampled LPNs, who must participate in continuing education programs, lacked specific dementia training for the last year. Interview with E1 (ED) on 1/3/15 at	

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	approximately 12:30 PM and with E2 (DON) at approximately 1:45 PM confirmed findings.	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED