

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

PRINTED: 09/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>08/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - ASHEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 BEAVERDAM ROAD</b> <b>ASHEVILLE, NC 28804</b>		
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{F 157} SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to notify the physician of medications not administered as ordered for 1</p>	{F 157}	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or	9/24/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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 157}	<p>Continued From page 1 of 2 sampled residents receiving dialysis treatments (Resident #108).</p> <p>The findings included:</p> <p>Resident #108 was admitted to the facility on 07/23/15 after hospitalization 07/13/15-07/23/15 with diagnoses which included end stage renal disease, hypertension, diabetes, coronary artery disease, seizures, glaucoma with blindness and esophagitis. Hospital records noted Resident #108 was diagnosed with latent syphilis and treatment initiated with weekly injections of Penicillin. Hospital records also noted that dialysis treatments had been initiated on 07/15/15 after placement of a PermCath on 07/14/15.</p> <p>Review of admission physician orders in the medical record of Resident #108 along with the July 2015 Medication Administration Record (MAR) noted the following medications were scheduled to be given:</p> <p>Aspirin, 81 milligrams (mg) by mouth every day (QD) and scheduled to be administered at 8:00 AM</p> <p>Colace (laxative), 100 mg by mouth QD and scheduled to be administered at 8:00 AM</p> <p>Imdur (for hypertension) 120 mg QD and scheduled to be administered at 8:00 AM</p> <p>Keppra (for seizures) 500 mg QD and scheduled to be administered at 8:00 AM</p> <p>Penicillin (an antibiotic) 4 milliliters (ml) intramuscularly one time a week for 2 doses and scheduled to be administered on 07/27/15</p> <p>Plavix (a blood thinner) 75 mg QD and scheduled to be administered at 8:00 AM</p> <p>Aldactone (a diuretic) 25 mg QD and scheduled to be administered at 8:00 AM</p> <p>Alphagan (for glaucoma) 1 drop both eyes two</p>	{F 157}	<p>agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>F 157 Resident #108 expired in the facility on 8/3/2015.</p> <p>All residents have the potential to be affected.</p> <p>The Director of Nurses/Designee will review eMARs of dialysis patients for the month of August for documentation of medication administration. Physician notification will be completed as indicated.</p> <p>The DNS/Designee will review time of medication administration for dialysis patients based on their dialysis schedule and review with the Physician for any changes needed.</p> <p>Licensed Nurses will receive in-service education on following Physician orders for medication administration to include notification if medication is not administered as ordered.</p> <p>DNS/Designee will review eMARS of all dialysis patients to ensure timely and accurate medication administration as well as physician notification if indicated x</p>		

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{F 157}	<p>Continued From page 2</p> <p>times a day (BID) and scheduled to be administered at 8:00 AM and 5:00 PM Bumex (a diuretic) 3 mg BID and scheduled to be administered at 8:00 AM and 5:00 PM Coreg (for hypertension) 12.5 mg BID and scheduled to be administered at 10:00 AM and 8:00 PM Trusopt (for glaucoma) 1 drop both eyes BID and scheduled to be administered at 10:00 AM and 8:00 PM MS Contin (for pain) 15 mg BID and scheduled to be administered at 8:00 AM and 5:00 PM Miralax (laxative) 17 grams BID and scheduled to be administered at 8:00 AM and 5:00 PM Pancrelipase (for digestion) 12,000 capsule three times a day (TID) and scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM Lanthanum Carbonate (decreases phosphate levels) 500 mg TID and scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM.</p> <p>Review of the medical record of Resident #108 noted dialysis was scheduled on Monday, Wednesday and Friday. Review of the medical record noted Resident #108 went to dialysis on 07/27/15 and 07/29/15. Resident #108 was scheduled to go to dialysis on 07/31/15 but refused. On 08/03/15 resident #108 expired at the facility.</p> <p>Review of nurses notes in the medical record of Resident #108 noted the following entries: 07/27/15-Nurse #2 noted that AM medications were not given because resident "not back from dialysis" 07/29/15-Nurse #3 noted 8:00 AM medications not administered. "Resident is out of facility at dialysis."</p>	{F 157}	<p>4 weeks, then weekly x 8 weeks.</p> <p>The results of the audits will be reported in the monthly Quality Assurance Performance Improvement (QAPI) Committee for 3 months, then the QAPI Committee will determine if further actions to are to be taken.</p>		

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{F 157}	<p>Continued From page 3</p> <p>Review of the July 2015 MAR for Resident #108 noted the following medications were documented as not given on 07/27/15 with reference to the nurses note written by Nurse #2: Aspirin, Colace, Imdur, Keppra, Penicillin, Plavix, Aldactone, Alphagon (8:00 AM dose), Bumex (8:00 AM dose), Coreg (10:00 AM dose), Trusopt (10:00 AM dose), Miralax (8:00 AM dose), Pancrelipase (8:00 AM dose) and Lanthanum Carbonate (8:00 AM dose). Review of the July 2015-August 2015 MAR for Resident #108 noted the Penicillin (scheduled to be given once a week and was due on 7/27/15) was never given.</p> <p>Review of the July 2015 MAR for Resident #108 noted the following medications were documented as not given on 07/29/15 by Nurse #3; noting LOA (leave of absence) as reason for not administering the medication: Aspirin, Colace, Imdur, Keppra, Plavix, Aldactone, Alphagon (8:00 AM dose), Bumex (8:00 AM dose), Coreg (10:00 AM dose), Trusopt (10:00 AM dose), Miralax (8:00 AM dose), Pancrelipase (8:00 AM dose and 12:00 PM dose) and Lanthanum Carbonate (8:00 AM dose and 12:00 PM dose).</p> <p>On 08/19/15 at 1:00 PM Nurse #2 verified that AM medications were not given to Resident #108 on 07/27/15 (as indicated on the MAR) because the resident was out of the facility at dialysis. Nurse #2 stated she was an agency nurse and had not received guidance during orientation on how to handle medication administration if a resident was out at dialysis. Nurse #2 stated she did not call the physician of Resident #108 or notify management nursing staff about the missed medication for Resident #108 on 07/27/15. Nurse #2 stated she did inform the</p>	{F 157}		

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{F 157}	<p>Continued From page 4</p> <p>oncoming nurse on 07/27/15 of the missed medications.</p> <p>On 08/19/15 at 1:30 PM Nurse #3 verified that medications were not given to Resident #108 on 07/29/15 (as indicated on the MAR) because the resident was out of the facility at dialysis. Nurse #3 stated she was an agency nurse and had not received guidance during orientation on how to handle medication administration if a resident was out at dialysis. Nurse #3 stated she asked a facility nurse for guidance and was told it was okay not to administer medication if a resident was out of the facility at dialysis. Nurse #3 stated she did not recall who the nurse was that she spoke to on 07/29/15. Nurse #3 stated it probably would have been a good idea to call the physician of Resident #108 but noted she did not call the physician or notify management nursing staff about the missed medication for Resident #108 on 07/29/15.</p> <p>On 08/19/15 at 4:30 PM the physician of Resident #108 noted Resident #108 came to the facility in a compromised condition and was very sick. The physician stated he did not remember being called about any concerns related to medication administration for Resident #108. The physician noted typically staff would notify him about medications for residents on dialysis so administration times could be adjusted; especially around the time of day the resident went to dialysis. The physician stated missed medications would have to be reviewed on an individual basis and that dialysis staff might have given the facility guidance as part of managing the resident's care.</p> <p>On 08/20/15 at 11:30 AM the manager of the</p>	{F 157}			

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{F 157}	Continued From page 5 dialysis center (where Resident #108 went for dialysis treatments) reported they never give guidance to a facility about medication administration and would anticipate medications would be administered as ordered by the resident's physician.  On 08/20/15 at 3:15 PM the Director of Nursing (DON) stated if a resident is not in the facility when a medication is due to be administered it should be held and the physician would be called for guidance on administration when the resident returned. The DON stated for residents that go out of the facility on a regular basis, like a dialysis resident, nursing staff should speak to the physician about ordering medication before or after dialysis. The DON stated orientation was given to agency nurses but wasn't sure if specific guidance was provided about medication administration for residents receiving dialysis. The DON stated she had not been asked about medication administration for Resident #108 and would have expected this to be brought to someone's attention.	{F 157}			
{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:	{F 246}		9/24/15	

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{F 246}	<p>Continued From page 6</p> <p>Based on observations, record reviews, resident interview and staff interview, the facility failed to keep a call bell within the reach of 1 of 3 residents sampled for call bells being in reach. (Resident #44).</p> <p>The findings included:</p> <p>Resident #44 was admitted to the facility on 07/05/13. Her diagnoses included cerebral vascular accident, hemiplegia affecting her dominant side and anxiety.</p> <p>The annual Minimum Data Set dated 06/06/15 coded her with intact cognition (scoring a 14 out of 15 on the Brief Interview for Mental Status), having unclear speech but being usually understood, and requiring extensive assistance with all activities of daily living skills. The communication Care Area Assessment dated 06/30/15 described Resident #44 as being alert and oriented to self and difficult to understand but can answer simple yes or no questions with ease.</p> <p>There was no care plan indicating special needs for the call bell and the care guide used by nurse aides for individual needs did not address the call bell for Resident #44.</p> <p>a. On 08/18/15 at 4:15 PM, Resident #44 was observed laying on top of a made bed, covered with a blanket. She had tears in her eyes and her chest was covered in vomit. The call bell was observed to be adapted with a pancake shaped end which was located on her right side, under the sheet of the made bed. At this time, staff was questioned. Nurse Aide (NA) #5 stated he had not laid her down in bed but that she was capable of using her call bell when she could reach it. NA</p>	{F 246}	<p>F 246</p> <p>Resident #44 has her call light within reach.</p> <p>All residents have the potential to be affected.</p> <p>A 100% audit of all residents in the facility were audited to ensure the call light is within reach.</p> <p>The Director of Nursing/Designee will in-service on placement of all call lights within resident's reach to all staff. In-service to nursing staff on placement of specialized call lights with residents identified.</p> <p>All residents needing a specialized call light will be identified through therapy screens.</p> <p>Call lights are audited by supervisors and management staff to ensure they are within reach of the resident at variable times throughout the day 5x/week for one month and then weekly thereafter. Auditing is reported daily to the ED/Designee. Weekly audits to validate call lights are within reach will be reported to monthly Quality Assurance Performance Improvement committee (QAPI) for 3 months, then QAPI will determine if further actions to are to be taken.</p>		

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{F 246}	<p>Continued From page 7</p> <p>#6 was interviewed on 08/18/15 at 4:20 PM and she stated NA #7 put Resident #44 to bed before she left first shift.</p> <p>Interview with Nurse #10 on 08/18/15 at 4:33 PM stated Resident #44 was capable of using the call bell when it was in her reach. She further stated the call bell was usually attached to her shirt so that she could reach it.</p> <p>On 08/18/15 at 5:09 PM Resident #44 was observed in clean clothes and in a clean bed. The call bell was on top of the sheet under the blanket cover by her right hand. Upon questioning, the resident using head nods and yes and no responses, indicated she could not use the call bell where it was located. The surveyor asked her to try to push the call bell but she could not access it. Resident #44 stated she usually could not reach the call bell. At this time Nurse #10 was questioned about the placement of the call bell and she moved the call bell on top of the covers where the resident could hit it with her left hand. The resident was observed with contracted hands and only the left arm was observed to have movement to access the call bell. Resident #44 indicated she would have pushed her call bell when she became ill if she could have reached it.</p> <p>A phone interview was conducted on 08/19/15 at 3:29 PM with NA #7. NA #7 stated that she had only worked with Resident #44 for a second time on 08/18/15. NA #7 stated she did not know that Resident #44 was able to utilize the call bell. She stated she had placed the call bell on top of the resident and she always clipped it to the resident.</p> <p>b. On 08/19/15 at 6:52 AM, Resident #44 was observed in bed with the call bell located on her</p>	{F 246}			



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{F 246}	<p>Continued From page 8</p> <p>pillow a few inches above the right side of her head. When asked, Resident #44 tried to reach the call bell with her left hand but could not reach it. On 08/19/15 at 7:01 AM, the Director of Nursing (DON) was asked about Resident #44's call bell. DON noted she could not reach the call bell and stated she would get a clip for the call bell.</p> <p>c. On 08/19/15 at 3:02 PM, Resident #44 was observed in bed with the call bell resting on the pillow above her head. When asked, Resident #44 attempted to reach the call bell with her left hand but could not reach it. She indicated that a male nurse aide put her to bed, but upon investigating the male nurse aide had already left for the day. NA #1 was interviewed on 08/19/15 at 3:06 PM. NA #1 stated Resident #44 can talk and has a communication board she could use for spelling out things. NA #1 stated she was capable of using the call bell and had done so when she wanted to be changed. Together the placement of the call bell was observed and NA #1 stated the call bell needed to be placed on her upper stomach/chest area so she could reach it.</p> <p>On 08/19/15 at 3:57 AM MDS nurse was interviewed. She stated that Resident #44 was capable of using a pancake pad type call bell and able to hold a few objects. She further stated that the call bell should be placed where the resident could reach it such as with her hand or with her head. she stated that it was a routine expectation that call bells should be in reach and therefore not listed on tenure aide care guides or care plan.</p> <p>On 08/20/15 at 12:02 PM NA #11 was interviewed via phone. NA #11 stated he did not have her assigned yesterday but that she was capable of</p>	{F 246}			

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{F 246}	Continued From page 9 using a regular call bell if it was placed it in her hand. He stated at times he placed the pancake bell close to her head so she can access it that way. Again he stated he thought another NA had her yesterday.	{F 246}			
{F 272} SS=D	On 08/20/15 at 3:25 PM the DON stated Resident #44 had more movement in her left upper extremity than her right and that the call bell needed to be where she could access it with her left hand. She stated that her access to the call bell was so special it should be noted on the care guide.  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; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	{F 272}		9/24/15	

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{F 272}	<p>Continued From page 10</p> <p>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 staff interviews, the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes, contributing factors and risk factors for 1 of 3 sampled residents reviewed for the most recent comprehensive Minimum Data Set (MDS). (Resident #68).</p> <p>The findings included:</p> <p>Resident #68 was admitted to the facility on 07/22/14. The MDS, an annual dated 07/24/15, coded Resident #68 as being cognitively intact, requiring extensive assistance with bed mobility, transfers, dressing, toileting and hygiene. She was nonambulatory, needed human assistance to balance with transitions, and was occasionally incontinent of bowel and bladder.</p> <p>Review of the CAAs dated 08/06/15 revealed</p>	{F 272}	<p>F272</p> <p>Residents #68 CAAs were updated on 9/10/2015 to identify and describe problems, strengths, or needs, causes and contributing factors or related risk factors and findings.</p> <p>Review of all CAAs to verify accuracy and modify as identified</p> <p>All CAAs will identify and clarify areas of concern that are triggered based on the MDS Assessment. Problem solving and decision making approaches of all the information available for each resident, making interventions that are individualized.</p> <p>The care plan team members will be</p>		

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{F 272}	Continued From page 11 documentation did not analyze Resident #68's individual strengths, weakness, abilities or how they affected her day to day function. The Activities of Daily Living Skills CAA noted she was obese and weak. The Urinary Incontinence CAA noted she was obese, had depression, mood disorder and required assistance with toileting. The Fall CAA noted she needed assistance of two for transfers and bed mobility, had conditions and received medications that may increase fall risk. The Psychotropic Drug use CAA was a check list with no narrative analysis.  On 08/20/15 at 1:09 PM, the MDS staff who completed the CAA for Resident #68 was interviewed. She stated that she was on leave when this CAA was completed on 08/06/15. She stated that she looked at what triggered, reviewed the care tracker information, reviewed written notes, physician orders and the medical record. She was aware the CAA needed to give a good picture of the resident and how the residents' specific information affected each area reviewed. MDS staff stated she did not include all the information she knew about Resident #68 in the CAAs.	{F 272}	educated by the Golden Living Clinical Assessment and Reimbursement Coordinator with emphasis on:  1. Consider each resident as a whole, with unique characteristics and strengths that affect the residents capacity to function. 2. Identify areas of concern that may warrant interventions 3. Develop interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well being. 4. Address the need and desire for other important considerations. Education was completed on 9/11/15.  A weekly audit will be performed on the prior week's Comprehensive Care Plans to ensure CAAs are completed and include problems, strengths or needs, causes and contributing factors or related risk factors and findings, x 3 months by the Golden Living Clinical Assessment and Reimbursement Coordinator.  Results of the weekly audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) Committee x 3 months then the QAPI Committee will determine if further actions to are to be taken.		
{F 281} SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility	{F 281}		9/24/15	

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{F 281}	<p>Continued From page 12 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interview and record reviews, the facility failed to administer a physician ordered supplement to 1 of 2 residents (Resident #69) reviewed for dialysis and the facility failed to consult with a physician prior to administering a medication, left at bedside and outside of the prescribed administration, for 1 of 1 resident (Resident #58) reviewed who received intravenous medication.</p> <p>The findings included:</p> <p>1. Resident #58 was admitted to the facility on 03/27/15. Diagnoses included paraplegia, chronic osteomyelitis, Diabetes type 2 and an open wound on the buttocks. Resident #58's quarterly Minimum Data Set (MDS) dated 08/12/15 recorded Resident #58 was cognitively intact and required extensive assistance with all activities of daily living.</p> <p>Resident #58's medical record was reviewed. Resident #58 was prescribed 600 milligrams (mg) of Ampicillin intravenously every 6 hours for wound infection. Resident #58 was also prescribed Meropenem 1 gram (gm) intravenously every 8 hours for wound infection. The morning dose of both medications was scheduled at 6:00 AM.</p> <p>Resident #58's medication administration record (MAR) was reviewed. Resident #58's morning doses of Ampicillin and Meropenem were recorded as administered by Nurse #4 on</p>	{F 281}	<p>F281</p> <p>Resident # 58 medications was removed from bedside and administered to resident on 8/19/15.</p> <p>Resident # 69 medication times were changed to accommodate dialysis schedule on 8/24/15.</p> <p>All residents have the potential to be affected.</p> <p>The Director of Nursing/Designee will audit all dialysis resident medication orders and notify the Physician for medication adjustments based on the dialysis treatment schedules. The DNS/Designee will complete 3 medication pass observations per week x 4 weeks.</p> <p>Inservice education will be provided for Licensed Nurses to meet Professional Standards of Quality to include following Physician orders in the administration of physician ordered supplements and medications.</p> <p>The DNS/Designee will review New Physician Orders and documentation of medication administration daily during clinical start-up. Any issues identified will result in one-to one retraining.</p>		

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{F 281}	<p>Continued From page 13 08/19/15 at 6:00 AM.</p> <p>Resident #58 was interviewed on 08/19/15 at 8:20 AM. Resident #58 reported Nurse #4 brought both doses of intravenous (IV) medications into his room the morning of 08/19/15 at approximately 6:00 AM. Resident #58 reported Nurse #4 initiated one of his IV medications at approximately 6:00 AM and exited his room leaving the second dose of IV medications on his bedside table. Resident #58 verbalized Nurse #4 did not return to his room on 08/19/15.</p> <p>Nurse #2 was interviewed on 08/19/15 at 9:53 AM. Nurse #2 reported she entered Resident #58's room at approximately 8:30 AM on 08/19/15 and discovered Resident #58's IV dose of Meropenem was sitting on Resident #58's bedside table. Nurse #2 verbalized she removed the IV dose of Meropenem from Resident #58's room and reported to Nurse #5 she had found IV medication sitting on Resident #58's bedside table.</p> <p>Nurse #5 was interviewed on 08/19/15 at 9:53 AM. Nurse #5 verbalized Nurse #2 had reported the discovery of IV medication on Resident #58's bedside table at approximately 8:30 AM on 08/19/15. Nurse #5 reported the IV medication discovered on Resident #58's bedside table was Meropenem 1 gm. Nurse #5 explained she reviewed Resident #58's MAR and noted the IV dose of Meropenem was documented as administered by Nurse #4 at 6:00 AM. Nurse #5 continued by explaining Resident #58 denied the IV dose of Meropenem had been administered. Nurse #5 reported she administered the IV Meropenem at 9:15 AM. Nurse #5 verbalized she</p>	{F 281}	The audits will be reported monthly to Quality Assurance Performance Improvement committee (QAPI) x 3 months then the QAPI Committee will determine if further actions are to be taken.		

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{F 281}	<p>Continued From page 14</p> <p>did not attempt to contact Nurse #4 or consult with the physician prior to administering the IV dose of Meropenem at 9:15 AM.</p> <p>Nurse #4 was interviewed on 08/20/15 at 6:08 AM. Nurse #4 verbalized she prepared Resident #58's medications for administration at approximately 6:00 AM on 08/19/15 and documented the medications were administered prior to Resident #58 receiving them. Nurse #4 reported she took both doses of IV medications into Resident #58's room and administered the Ampicillin while leaving the Meropenem on Resident #58's bedside table. Nurse #4 added she forgot to return to Resident #58's room and administer the Meropenem.</p> <p>The Director of Nursing (DON) was interviewed on 08/20/15 at 4:23 PM. The DON verbalized medications should not be left unattended in residents' rooms and medications should be administered within one hour of their scheduled time. The DON also verbalized it is her expectation when there is uncertainty concerning a medication's administration an attempt be made to contact all staff with knowledge related to the medications administration and consult with the physician prior to administering the medication.</p> <p>2. Resident #69 was admitted to the facility on 01/22/15 with diagnoses including ankle fractures, diabetes, pressure ulcers, and end stage renal disease. Resident #69 went to dialysis Mondays, Wednesdays and Fridays.</p> <p>The quarterly Minimum Data Set dated 06/29/15 coded Resident #69 with intact cognition (scoring a 15 out of 15 on the Brief Interview for Mental</p>	{F 281}			

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{F 281}	<p>Continued From page 15 Status) and receiving dialysis services.</p> <p>Review of the physician orders for August 2015 revealed Resident #69 was ordered the following three times a day: *Prostat Max (liquid protein) 30 milliliters (ml) three times per day for wound healing.</p> <p>Review of the Medication Administration Records (MAR) for August 2015 revealed missed the protein supplement as follows: *Prostat Max scheduled for 12:00 PM was missed Wednesday 08/05/15 for being on leave; on Friday 08/07/15 for "other" reason; on Friday 08/14/15 for being on leave; and on Monday 08/17/15 for being on leave.</p> <p>On 08/19/15 at 1:28 PM Nurse #3, who worked Friday 08/14/15, stated during interview that she tried to give Resident #69 her the ordered supplements before she left for dialysis but sometimes she did not get to her in time. She stated that she marked the MAR that she was unavailable and passed it on to second shift nurses. She stated she did not inform the physician.</p> <p>On 08/19/15 at 1:45 PM, Nurse #2, who worked Friday 08/07/15, was interviewed and stated that she would mark the MAR with a "7" (meaning other) if Resident #69 was at dialysis by the time she was administering the noon supplements. She stated that when that occurred, she did not report it to the physician but did report it to the oncoming nurse. She further stated she had not received any training regarding how to handle the scheduled medications if the resident was at dialysis.</p>	{F 281}			



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{F 281}	<p>Continued From page 16</p> <p>On 08/19/15 at 3:12 PM a phone interview was conducted with Nurse #7, who worked Wednesday 08/05/15. She stated that if a resident was at dialysis at the time a physician ordered supplement was due to be given, she would code that the resident was on leave on the MAR. She stated she was not trained on what to do if a physician order was not able to be given because a resident was at dialysis. She did not inform the physician as she was not instructed to do so. Nurse #7 further stated that since she always went to dialysis three times a week at the same time Monday, Wednesday and Friday, everyone knew she did not receive the scheduled supplements. She continued saying that there were no extraneous orders to hold the supplement or call the doctor.</p> <p>On 08/19/15 at 4:17 PM a phone interview was held with the attending physician. The physician stated that normally when a resident was at dialysis during a medication time, the staff called him to obtain a clarification or time change for the supplement. He further stated that the supplement missed during the 3 dialysis days would not be a hardship on the resident.</p> <p>A phone interview with Nurse #6, who worked Monday 08/17/15, was conducted. Nurse #6 stated that Resident #69 had already left for dialysis when went to give her the supplement on 08/17/15. She stated that was the first time she had that assignment and would have tried to give her the supplement before she left for dialysis, she stated she did not call the physician because the policy was that the physician did not have to be notified unless the orders were held twice.</p> <p>Interview with the Director of Nursing (DON) on</p>	{F 281}			

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{F 281}	Continued From page 17 08/20/15 at 3:14 PM revealed that for dialysis residents, staff should obtain a physician's order to give the physician ordered supplements before the resident goes to dialysis, after the resident returns from dialysis, or obtain a change in time for the orders set up with the dialysis schedule. DON stated she was unaware that Resident #69 was not receiving the supplement due to being at dialysis.	{F 281}			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement care planned interventions to prevent falls for 1 of 4 residents sampled for accidents. (Resident #38).  The findings included:  Resident #38 was admitted to the facility on 02/09/06 with diagnoses including tremors, hypertension and senile dementia with delusional features.  The most recent Minimum Data Set (MDS), a quarterly dated 06/03/15, coded her with severely impaired cognition, requiring extensive assistance for bed mobility, transfers, walking and toileting. The MDS coded her as needing human assistance to stabilize with balance during	F 282	F282  . For Resident #38, a chair alarm was placed, a non-skid mat was placed at bedside, and dycem was placed in wheelchair on 8/19/15. Care plan was updated on 8/20/15.  All residents have the potential to be affected.  All residents with fall care plans are audited to make sure care plan interventions to prevent falls are in place.  The Director of Nursing/Designee will update care plans for fall interventions during clinical startup.	9/24/15	

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F 282	<p>Continued From page 18</p> <p>transitions. Resident #38 had no falls during the assessment period.</p> <p>A Care Plan last reviewed on 06/11/15 addressed Resident #38's risk for falls related to being unsteady on her feet, receiving a daily antidepressant and having a history of falls. The interventions included:</p> <ul style="list-style-type: none"> <li>*bed and chair alarms as ordered;</li> <li>*dycem (nonskid material) in wheelchair;</li> <li>*non-skid mat at bedside; and</li> <li>*room close to nurse's station</li> </ul> <p>The August 2015 computerized physician orders included bed and chair alarms at all times check placement and function q shift.</p> <p>A care guide was established for nursing assistants' reference that included individual needs for each resident. Per the care guide last updated 08/18/15, Resident 38 needed bed and chair alarms and staff to check on resident frequently as she tried to get up alone. The care guide did not include a dycem in the wheelchair or mats on the floor.</p> <p>On 08/18/15 at 12:45 PM, Resident #38 was observed in her room, located at the very end of the hall, farthest away from the nursing station. She was in bed, no alarm was visible on the bed and there were no nonskid mats on the floor or observed in the room.</p> <p>On 08/18/15 at 2:46 PM, Resident #38 was observed in bed with her right leg hanging off the bed, no alarm or floor mats in place.</p> <p>On 08/18/15 at 3:08 PM, Resident #38 was observed sitting on the edge of her bed. She had</p>	F 282	<p>The Director of Clinical Education/Designee will re-educate clinical nursing staff on following Care Plan interventions. Care Plan interventions will be communicated to the Nursing Staff by the use of Care Cards.</p> <p>The DNS/Designee will complete observations of 5 residents with fall precaution interventions daily x 2 weeks, then 3 x per week x 2 months. The observations will be maintained in the Executive Director's office.</p> <p>The observations will be reported monthly to the Quality Assurance Performance Improvement(QAPI)Committee x 3 months, then the QAPI Committee will determine if further actions to are to be taken.</p>		

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F 282	<p>Continued From page 19</p> <p>no alarm in the bed. Nurse Aide (NA) #12 entered the room and stated she normally did not work this end of the hall and had only been in the facility approximately 2 weeks. She stated she referred to the care guide for information. NA #12 assisted Resident #38 pivot to the wheelchair, which had a pressure pad under the seat cushion but was not connected to an alarm box and had no dycem on top or below the seat cushion. NA #12 pushed Resident #38 into the bathroom and then left her sitting in the wheelchair in the bathroom doorway at 3:13 PM to give the nurse a small white pill she had found in the resident's bed. While the aide had left the room, Resident #38 proceeded to pull herself to a standing position in front of the toilet. NA #12 returned with another staff member to find the resident standing in front of the toilet. NA #12 stated she did not know if Resident #38 was supposed to have any alarms. Resident #38 was observed sitting in her wheelchair without a connected alarm on 08/18/15 at 3:23 PM.</p> <p>On 08/18/15 at 4:09 PM, Resident #38 was observed in bed with the wire that connected the sensor pad in bed to the alarm box disconnected and on the floor. There were no mats on the floor. On 08/18/15 at 4:39 NA #1 was interviewed and stated she assisted in the resident laying back down and had been in the facility approximately 2 weeks. At 4:59 PM, NA #1 stated that she knew what the residents needed by asking the alert and oriented residents or asking a nurse. She stated there was a care guide also available for review. She stated that normally the alarms were always in place and on so she may not have checked to assure the alarm was functioning. Together at 5:03 PM NA #1 and the surveyor observed the alarm box not connected. NA #1 stated it was in</p>	F 282			

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F 282	<p>Continued From page 20</p> <p>place and working Sunday and it was also in the wheelchair. NA #1 confirmed that there was no alarm in the wheelchair when she assisted her to bed this afternoon. When asked about the floor mats, NA #1 stated she was not aware of any floor mats for this resident and none were located in the room.</p> <p>On 08/19/15 at 8:11 AM and at 9:01 AM, Resident #38 was observed in bed, the alarm was on and functioning but there was no floor mat in place. On 08/19/15 at 10:57 AM, NA #4 was assisting her from the bathroom to wash her hands. There was no alarm in the wheelchair at this time. On 08/19/15 at 11:03 AM, Resident #38 was observed in her wheelchair in the doorway of her room. There was no alarm on the wheelchair. At 11:19 AM, Resident #38 was in her wheelchair with no alarm in place and she rolled back into her room.</p> <p>On 08/19/15 at 11:34 AM, NA #4 was interviewed and stated Resident #38 normally had a pressure type alarm in her wheelchair that activated upon sitting. She stated the alarm would beep when the resident sat in the chair. NA #4 stated she did not pay attention to whether the alarm beeped when she transferred her into the wheelchair this date. She confirmed there was no alarm in the wheelchair at this time. She further stated that all the resident required for fall prevention was bed and chair alarms but no floor mats based on the care guide.</p> <p>Review of the Medication Administration Record (MAR) for Resident #38 revealed Nurse #2 signed off that the bed and chair alarms had been in place first shift on 08/18/15. On 08/19/15 at 11:37 AM, Nurse #2 stated she was supposed to</p>	F 282			

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F 282	Continued From page 21 visualize the alarms but she did not look yesterday (08/18/15) when she marked the MAR that the alarm was on and functioning.  Interview with the Director of Nursing (DON) on 08/19/15 at 2:33 PM revealed the care guides were reviewed during morning meetings and should include anything special for each resident. DON stated the floor mat and dycem should have been included on the care guide for Resident #38. She expected all care planned interventions to be in place for Resident #38. DON stated Resident #38 was never moved closer to the nursing station and that intervention should have been removed from the care plan.	F 282			
{F 309} SS=D	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.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff and resident interviews, the facility failed to measure and treat a diabetic foot ulcer for 1 of 4 sampled residents reviewed for wound care. (Resident #111)  The findings included:  Resident #111 was admitted to the facility	{F 309}	F309  Resident #111 had treatment put in place on 8/20/15. Wound was measured by DNS on 8/20/15.  All residents with wounds have the potential to be affected.	9/24/15	

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{F 309}	<p>Continued From page 22</p> <p>08/04/15 after hospitalization for treatment of a diabetic foot ulcer. Admitting diagnoses included diabetes, venous insufficiency and peripheral vascular disease.</p> <p>Hospital discharge records included in the medical record of Resident #111 included both medication and treatment orders. Treatment discharge orders included, "Paint Betadine solution to the posterior right heel wound."</p> <p>An admission Minimum Data Set assessment dated 08/11/15 assessed Resident #111 with no cognitive impairment and included a Care Area Assessment in the area of pressure sores which included the following, Resident has diagnosis of diabetes, peripheral neuropathy, venous insufficiency and has an amputation of the left lower leg. Assessments indicate resident has an unstageable area on his right heel. Progress notes and physician orders indicate resident has a special mattress and chair cushion for prevention. Progress notes indicate resident needs some assistance with transfers at this time. History and physical indicates resident has some diagnoses which can increase risk for pressure ulcers. Resident will be care planned to prevent further loss of skin integrity, to promote healing of current areas and to improve overall skin integrity and mobility by participation with therapies, encouraging resident to do as much as possible independently, skin treatments as ordered and assessments of skin per facility policy.</p> <p>The care plan dated 08/14/15 for Resident #111 included a problem area, Pressure ulcer and potential for other pressure ulcers. Approaches to this problem area included:</p>	{F 309}	<p>An audit of all residents with wounds will be completed to ensure treatments are in place and measurements recorded.</p> <p>The Director of Clinical Education/Designee will provide education to wound nurse and license nursing staff on Golden Living Wound Care guidelines.</p> <p>Education addressing wound treatment will be provided by area wound center to license nursing staff.</p> <p>The Director of Nursing/Designee will review and audit all new admissions with wounds and newly identified skin issues during clinical startup. The Director of Clinical Education/Designee will observe the license nurse completing wound care treatments weekly x4 weeks, then monthly. Audits of wound measurements will be completed weekly during At Risk Meeting.</p> <p>The audits will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee x 3 months then the QAPI Committee will determine if further actions to be taken.</p>		

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{F 309}	<p>Continued From page 23</p> <p>-conduct weekly skin inspection</p> <p>-treatments as ordered</p> <p>The August 2015 Treatment Administration Record (TAR) for Resident #111 included an entry for Weekly skin review noting these were due 08/05/15, 08/12/15 and 08/19/15. The weekly skin assessments included:</p> <p>08/04/15-Unstageable ulcer on right heel, not seen.</p> <p>08/12/15-Wound to right foot.</p> <p>08/20/15-Right heel vascular wound, .5 centimeters X .5 centimeters X .2 centimeters</p> <p>Review of physician orders in the medical record of Resident #111 noted no orders for treatments until 08/20/15. On 08/20/15 an order was written in the medical record of Resident #111 to, "Paint Betadine solution to posterior right heel wound. Wrap foot with Kerlix and secure with tape one time a day." Per review of the TAR, the treatment was initiated on 08/20/15.</p> <p>On 08/20/15 at 1:00 PM the facility treatment nurse stated she was new in the position and, in her role, had completed skin assessments the week prior. The treatment nurse stated she had completed the 08/12/15 weekly skin assessment noting the wound to the right foot of Resident #111. The treatment nurse stated she did not measure the wound because she did not have a tool for measurement. The treatment nurse stated she just started doing wound treatments on 08/17/15 and, on that date was doing rounds with the wound physician. The treatment nurse stated the wound physician did not see Resident #111 because the resident had a future appointment scheduled with a podiatrist. The treatment nurse could not explain why treatments</p>	{F 309}			



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{F 309}	<p>Continued From page 24</p> <p>had not been initiated for the wound on Resident #111's right heel wound until 08/20/15.</p> <p>On 08/20/15 at 1:10 PM Resident #111 was observed in his room with a dressing on his right foot. Resident #111 reported the treatment nurse had been in his room earlier to do the treatment and dressing to his right foot.</p> <p>On 08/20/15 at 2:15 PM the Director of Nursing (DON) stated the discharge order for treatment from the hospital had been missed when Resident #111 was admitted to the facility. The DON stated treatments should have been done on a daily basis and included on the TAR since Resident #111 was admitted on 08/04/15. The DON stated there should have been more specific description of the vascular wound on Resident #111's right heel, including measurements. The DON stated she had not reviewed the weekly skin assessments to realize the wound had not been measured. The DON stated she did a measurement of the wound on 08/20/15 which was reflected in the 08/20/15 weekly skin assessment. The DON stated because there were not any measurements until 08/20/15 she did not know if the wound had improved since admission.</p> <p>On 08/20/15 at 4:00 PM Nurse #1 stated he admitted Resident #111 on 08/04/15. Nurse #1 stated he completed admission orders for Resident #111 based on hospital discharge orders. Nurse #1 had no explanation why the area on the right heel of Resident #111 was not measured during the admission on 08/04/15. Nurse #1 reviewed the hospital discharge orders and stated he missed the order for treatment to the resident's right heel. Nurse #1 stated the</p>	{F 309}			

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{F 309}	Continued From page 25 treatment orders for the right heel should have been included on admission on the TAR for Resident #111. Nurse #1 stated he was aware of the area on the resident's right heel and that the resident usually asked him to do treatments when he was on duty.	{F 309}			
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to implement interventions including weekly skin sweeps, treatments as ordered, offloading pressure ulcers, and providing ordered yogurt snacks to promote the healing of pressure ulcers for 1 of 4 residents sampled for pressure ulcers. (Resident #69).  The findings included:  Resident #69 was admitted to the facility on 01/22/15 with diagnoses including ankle fractures, diabetes, pressure ulcers, and end stage renal disease. Resident #69 was seen by an out of facility wound physician.	{F 314}	F314  Resident # 69 ankle ring was placed on left leg while in bed on 8/20/15. Measurements of resident's wounds were obtained from wound doctor as of 8/18/15. Treatment will be performed before leaving for dialysis and in the evening after return.  All residents have the potential to be affected.  An audit of all residents receiving wound treatments will be reviewed for completion of treatments. Treatment nurse will audit	9/24/15	

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{F 314}	Continued From page 26  The quarterly Minimum Data Set dated 06/29/15 coded Resident #69 with intact cognition (scoring a 15 out of 15 on the Brief Interview for Mental Status), receiving a therapeutic diet and having 3 unhealed unstageable pressure ulcers with 2 being present since last assessment.  A care plan last updated on 07/24/15 addressed actual pressure ulcers to the left foot and left ankle. The goal was for the open areas to heal without complication. Interventions included conduct weekly skin inspections, nutritional and hydration support, offload heels at all times with foam boots, and treatments as ordered.  July 2015 physician orders included: *Silvadene wet to dry dressing on left heel, wrap with kerlex twice daily, offload heels at all times, push protein intake; *heels elevated off mattress or any surface at all times; *please send yogurt with resident for 2 PM snack while at dialysis Monday, Wednesday and Friday; and *weekly skin review every Monday.  Resident #69 was seen at the wound clinic on 08/04/15. The Patient Treatment Update noted: *the left medial ankle, present approximately 6 months, measured 0.5 centimeters (cm) x 0.7 cm x 0.3 cm and the ulcer bed had exposed bone tissue. *the left heel, present approximately 6 months, measured 6.3 cm x 6 cm x 0.2 cm and the ulcer bed had exposed subcutaneous tissue and the skin around the ulcer was macerated. *the left lateral heel, present for approximately 9 days, measured 1.4 cm x 1.4 cm x 0.1 cm and	{F 314}	all residents with pressure relieving interventions to ensure interventions are in place.  The Director of Nursing/Designee will educate nursing staff on Golden Living wound care guidelines. New hires, permanent and temporary, will be educated on Golden Living wound care guidelines during orientation.  Education addressing wound treatment will be provided by area wound center to nursing staff  The Director of Nursing/Designee will review all residents with wounds during weekly At Risk meetings. The Director of Nursing/Designee will audit residents to ensure care plan interventions are in place weekly x 4weeks, then monthly.  The audits will be reported monthly to Quality Assurance Performance Improvement committee (QAPI) x 3 months then QAPI will determine if further actions to be taken.		

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{F 314}	<p>Continued From page 27</p> <p>the ulcer bed had exposed bone tissue. Physician orders dated 08/04/15 included the continuation of Silvadene twice daily to the 3 ulcers, offload heel while in bed with ankle ring and push protein.</p> <p>Resident #69 was seen at the wound clinic on 08/18/15. The Patient Treatment Updated noted: *the left medial ankle measured 0.5 cm x 0.6 cm x 0.3 cm; *the left heel measured 7.4 cm x 6 cm x 0.2 cm; and *the left lateral heel was healed.</p> <p>Physician ordered dated 08/18/15 included Dakins 0.125% wet to dry dressings to the left heel and medial ankle ulcer twice per day, offload the ulcers when in bed (pillow float, ankle ring) and push protein. The resident was also ordered an antibiotic for the suspected presence of Methicillin resistant staphylococcus aureus (MRSA) in the wound.</p> <p>A care guide used by the nurse aides (NA) that reflected residents' individual needs dated 08/18/15 noted the interventions included to offload heels with foam booties, send yogurt for 2 PM snack while at dialysis. Ankle rings were not included on the care guide for staff reminders.</p> <p>A. Review of the Treatment Administration Records (TAR) revealed blanks indicating the Silvadene treatment was not done day or evening shift on Sunday 07/26/15; day shift on 07/30/15 and 07/31/15; and day or evening shift on 08/04/15. The Dakins was not initialed as being given on day shift 08/09/15, 08/14/15 and 08/17/15.</p> <p>Observations and interviews about the</p>	{F 314}			

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{F 314}	Continued From page 28 treatments: *On 08/18/15 at 1:19 PM, Resident #69 was interviewed. She stated her dressings were to be changed twice a day but she was lucky if they were changed once a day. Resident #69 stated that there were so many temporary staff and that when she asked they told her it was not in their job description to change the dressings. *On 08/20/15 at 9:07 AM, Resident #69 stated that she felt her treatments were missed mostly on dialysis days as the staff just didn't find the time to do her treatments twice per day. *On 08/20/15 at 9:38 AM, Nurse #6 was interviewed via phone. Per the TAR, she had been working on 08/17/15. Nurse #6 stated Monday 08/17/15 she did not do the treatment for Resident #69 because the resident had already gone to dialysis when she was ready to do the treatment. *On 08/20/15 at 9:45 AM the treatment nurse stated she did skin sweeps the first week she was at the facility and just started doing wound care on Monday. (08/17/15). She stated that the wound physician was in the building on 08/17/15 and she went around with him. She stated that she did not do Resident #69's treatment on 08/17/15 because by the time she was done with accompanying the wound physician, it was time for her to go home. Treatment Nurse stated she had already left for dialysis by the time she got to the floor the morning of 08/17/15. She further stated that if for some reason she was not able to do the treatment for a resident, she let the floor nurse know so they could do it. *On 08/20/15 at 10:15 AM a phone interview was conducted with Nurse #8 who revealed that sometimes she was unable to get the treatments done. *On 08/20/15 at 11:08 AM phone interview with	{F 314}			

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{F 314}	<p>Continued From page 29</p> <p>Nurse #9 who worked on the day shift of 08/04/15 was conducted. Nurse #9 stated she could not recall if she did the treatment on 08/04/15. She stated she should have initialed the treatment if she completed it but it was her first day at the facility and she worked 11 hours due to it being a very hectic day and she could not recall.</p> <p>*On 08/20/15 at 11:22 PM a phone interview with Nurse #3, who worked the day shifts on 07/26/15, 08/09/15 and 08/14/15 was conducted. Nurse #3 revealed she did not do Resident #69's treatments on 07/26/15, 08/09/15 or 08/14/15 because by the time she had finished medication pass, she did not have time to do the treatments. She stated she informed second shift she had not done the treatments.</p> <p>B. The TAR indicated blanks for offloading bilateral heels on 07/26/15 all three shifts; on 07/30/15 and 07/31/15 day and evening shifts or on 08/05/15; and to offload heels with an ankle ring during day shift on 08/06/15, 08/09/15, 08/14/15 and 08/17/15.</p> <p>Observations and interviews revealed the following about the ankle rolls: *On 08/18/15 at 4:45 PM NA #1 was observed transferring Resident #69 to bed. NA #1 placed a pillow under her legs to float her heels. *On 08/19/15 at 9:18 AM, Resident #69's heels were observed directly on the pillow and not floated. She stated she had never had ankle rings to float her heels. *On 08/19/15 at 10:02 AM, the treatment nurse changed the dressings on Resident #69's left ankle and heel. There were 2 distinct areas, one on the ankle and one covering the heel. The treatment nurse left her heels floating on a pillow. The treatment nurse stated she knew what the</p>	{F 314}			

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{F 314}	<p>Continued From page 30</p> <p>ankle rings looked like but she had never seen them in use for Resident #69.</p> <p>*On 08/19/15 at 10:54 AM no booties or ankle ring was observed and her heels were on the mattress.</p> <p>*On 08/19/15 at 1:58 PM Nurse # 1 stated he had not seen any ankle ring and normally rolled a pillow to float heels.</p> <p>*On 08/20/15 at 9:00 AM the central supply staff stated and showed the surveyor there were ankle rings in stock. The Central Supply Clerk stated she ordered them for Resident #69 and made sure she delivered them to Resident #69.</p> <p>Observations in Resident #69's room revealed ankle rings were found in her closet on 08/20/15 at 9:07 AM at which time the resident's feet were not being floated by any means. Resident #69 was shown the ankle rings and stated she could not recall ever using them. She further stated that she was very aware of her heels as she was fearful of amputation.</p> <p>*On 08/20/15 at 9:15 AM NA #2 and NA #3 stated they had never seen ankle rings for Resident #69 and they just propped her feet on pillows.</p> <p>C. The dialysis center's registered dietician sent a physician's order for yogurt to be sent as a 2 PM snack on dialysis days for added nutrition and protein for malnourishment and wound healing since 04/15/15. Yogurt was initialed as being sent each dialysis day per the July and August Medication Administration Record (MAR).</p> <p>Observations and interviews about the yogurt: *On 08/19/15 at 11:19 Resident #69 received 2 warm sandwiches, 2 packages of graham crackers and milk to take to dialysis with her. There was no yogurt in her packed lunch and she stated she never received yogurt.</p>	{F 314}			

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{F 314}	<p>Continued From page 31</p> <p>*On 08/19/15 at 12:51 PM Nurse #3, who signed for yogurt twice in August, stated that she told the nurse aides to get her yogurt and signed off that she received the yogurt on dialysis days.</p> <p>*On 08/19/15 at 12:58 Nurse #2 stated that she never checked to see that Resident #69 received the yogurt on dialysis days as she expected the kitchen to pack it in her lunch on dialysis days.</p> <p>*On 08/19/15 at 1:38 PM the facility's Registered Dietician (RD) stated during interview that the physician ordered yogurt to be sent on dialysis days, however, no communication sheet was found in the kitchen and the kitchen had not been sending yogurt with Resident #69 on dialysis days because the kitchen was unaware of this order.</p> <p>*On 08/19/15 at 1:00 PM NA #4 stated she usually got Resident #69's lunch from the kitchen on dialysis days and had never seen yogurt sent with her.</p> <p>*On 08/19/15 at 1:15 dietary staff #1 stated she fixed the dialysis lunches and Resident #69 was not sent yogurt with her lunches.</p> <p>*On 08/20/15 at 9:07 AM, Resident #69 stated she never received yogurt with her dialysis lunch and she loved yogurt.</p> <p>*On 08/20/15 at 11:47 AM the dialysis RD was interviewed via phone. She stated the yogurt was ordered for wound healing and her malnourishment.</p> <p>D. The skin sweeps were documented being done by Nurse #2 on 07/27/15, 08/07/15 and 08/10/15. The Medication and treatment records were blank regarding any skin sweep done on 08/17/15.</p> <p>*Review of the weekly skin sweeps revealed a weekly skin review dated 07/25/15 which checked that there was a pre-existing open are on the left</p>	{F 314}			



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{F 314}	Continued From page 32 heel. Documentation revealed the wound was being treated by a wound clinic. *Weekly skin review dated 08/03/15 noted the resident had gone to dialysis and no review was documented. *On 08/11/15 the treatment nurse completed a skin sheet which noted a left heel wound with MRSA. There was nothing documented about the left ankle or any measurements or descriptions. *On 08/20/15 at 9:45 AM the treatment nurse stated she did skin sweeps the first week she was at the facility and just started doing wound care on Monday (08/17/15). *On 08/20/15 at 4:10 PM the treatment nurse stated that she did not measure the wounds per the skin sweep on 08/11/15 because she did not have any way to measure them. She stated she should have indicated the left heel included the left ankle area.  On 08/20/15 at 2:16 PM, the Director of Nurses (DON) stated that she expected weekly wound assessments should include descriptions of all the wounds and measurements. In addition a wound sweep should also have been completed on Monday 08/17/15. She expected treatments to be completed as ordered and interventions updated on the care plan and care guides.	{F 314}			
{F 333} SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by:	{F 333}		9/24/15	

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{F 333}	<p>Continued From page 33</p> <p>Based on observations, medical record review and staff and resident interviews the facility failed to administer medications to 2 of 2 sampled residents receiving dialysis treatments (Residents #69 and #108) and failed to administer an anti-seizure medication within the prescribed timeframe to 1 of 3 residents (Resident #58) observed during medication pass.</p> <p>The findings included:</p> <p>1. Resident #108 was admitted to the facility on 07/23/15 after hospitalization 07/13/15-07/23/15 with diagnoses which included end stage renal disease, hypertension, diabetes, coronary artery disease, seizures, glaucoma with blindness and esophagitis. Hospital records noted Resident #108 was diagnosed with latent syphilis and treatment initiated with weekly injections of Penicillin. Hospital records also noted that dialysis treatments had been initiated on 07/15/15 after placement of a PermCath on 07/14/15.</p> <p>Review of admission physician orders in the medical record of Resident #108 along with the July 2015 Medication Administration Record (MAR) noted the following medications were scheduled to be given:</p> <p>Aspirin, 81 milligrams (mg) by mouth every day (QD) and scheduled to be administered at 8:00 AM</p> <p>Colace (laxative), 100 mg by mouth QD and scheduled to be administered at 8:00 AM</p> <p>Imdur (for hypertension) 120 mg QD and scheduled to be administered at 8:00 AM</p> <p>Keppra (for seizures) 500 mg QD and scheduled to be administered at 8:00 AM</p> <p>Penicillin (an antibiotic) 4 milliliters (ml) intramuscularly one time a week for 2 doses and</p>	{F 333}	<p>F333</p> <p>Resident #108 expired on 8/3/15.</p> <p>Resident # 69 had medication error report completed and physician notified of medication errors on 8/19/15. Residents #69 experienced no adverse effects from omission of Renvela and Metoclopramide.</p> <p>Resident # 14 Medication error report completed and physician was notified of medication error on 8/21/15. The resident experienced no adverse effects from Tegretol being administered late. Medication administration time was changed to ensure prompt administration on 8/26/15.</p> <p>All residents have the potential to be affected. Current resident eMARs will be audited for the month of August for timely administration of medications by the DNS/Designee.</p> <p>The DNS/Designee will review medication times including attention to dialysis residents. Times will be changed to ensure prompt administration of medications.</p> <p>Inservice education will be provided for Licensed Nurses to meet Professional Standards of Quality to include following physician orders in administration of supplements and medications.</p> <p>The DNS/Designee will review New</p>		

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{F 333}	<p>Continued From page 34</p> <p>scheduled to be administered on 07/27/15 Plavix (a blood thinner) 75 mg QD and scheduled to be administered at 8:00 AM Aldactone (a diuretic) 25 mg QD and scheduled to be administered at 8:00 AM Alphagan (for glaucoma) 1 drop both eyes two times a day (BID) and scheduled to be administered at 8:00 AM and 5:00 PM Bumex (a diuretic) 3 mg BID and scheduled to be administered at 8:00 AM and 5:00 PM Coreg (for hypertension) 12.5 mg BID and scheduled to be administered at 10:00 AM and 8:00 PM Trusopt (for glaucoma) 1 drop both eyes BID and scheduled to be administered at 10:00 AM and 8:00 PM MS Contin (for pain) 15 mg BID and scheduled to be administered at 8:00 AM and 5:00 PM Miralax (laxative) 17 grams BID and scheduled to be administered at 8:00 AM and 5:00 PM Pancrelipase (for digestion) 12,000 capsule three times a day (TID) and scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM Lanthanum Carbonate (decreases phosphate levels) 500 mg TID and scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM.</p> <p>Review of the medical record of Resident #108 noted dialysis was scheduled on Monday, Wednesday and Friday. Review of the medical record noted Resident #108 went to dialysis on 07/27/15 and 07/29/15. Resident #108 was scheduled to go to dialysis on 07/31/15 but refused. On 08/03/15 resident #108 expired at the facility.</p> <p>Review of nurses notes in the medical record of Resident #108 noted the following entries: 07/27/15-Nurse #2 noted that AM medications</p>	{F 333}	<p>Physician Orders for dialysis residents for time administration based on their dialysis schedule during clinical start-up and review with the Physician for any changes needed. The DNS/designee will complete medication pass observations for timely administration 3 x per week x 4 weeks. Any issues identified will result in one-to-one retraining.</p> <p>The audits will be reported to Quality Assurance Performance Improvement (QAPI) Committee x 3 months, then the QAPI committee will determine if further actions are to be taken.</p>		

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{F 333}	<p>Continued From page 35</p> <p>were not given because resident "not back from dialysis"</p> <p>07/29/15-Nurse #3 noted 8:00 AM medications not administered. "Resident is out of facility at dialysis."</p> <p>Review of the July 2015 MAR for Resident #108 noted the following medications were documented as not given on 07/27/15 with reference to the nurses note written by Nurse #2: Aspirin, Colace, Imdur, Keppra, Plavix, Aldactone, Alphagon (8:00 AM dose), Bumex (8:00 AM dose), Coreg (10:00 AM dose), Trusopt (10:00 AM dose), Miralax (8:00 AM dose), Pancrelipase (8:00 AM dose) and Lanthanum Carbonate (8:00 AM dose). Review of the July 2015-August 2015 MAR for Resident #108 noted the Penicillin (scheduled to be given once a week and was due on 7/27/15) was never given.</p> <p>Review of the July 2015 MAR for Resident #108 noted the following medications were documented as not given on 07/29/15 by Nurse #3; noting LOA (leave of absence) as reason for not administering the medication: Aspirin, Colace, Imdur, Keppra, Plavix, Aldactone, Alphagon (8:00 AM dose), Bumex (8:00 AM dose), Coreg (10:00 AM dose), Trusopt (10:00 AM dose), Miralax (8:00 AM dose), Pancrelipase (8:00 AM dose and 12:00 PM dose) and Lanthanum Carbonate (8:00 AM dose and 12:00 PM dose).</p> <p>On 08/19/15 at 1:00 PM Nurse #2 verified that AM medications were not given to Resident #108 on 07/27/15 (as indicated on the MAR) because the resident was out of the facility at dialysis. Nurse #2 stated she was an agency nurse and had not received guidance during orientation on</p>	{F 333}			

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{F 333}	<p>Continued From page 36</p> <p>how to handle medication administration if a resident was out at dialysis. Nurse #2 stated she did not call the physician of Resident #108 or notify management nursing staff about the missed medication for Resident #108 on 07/27/15. Nurse #2 stated she did inform the oncoming nurse on 07/27/15 of the missed medications.</p> <p>On 08/19/15 at 1:30 PM Nurse #3 verified that medications were not given to Resident #108 on 07/29/15 (as indicated on the MAR) because the resident was out of the facility at dialysis. Nurse #3 stated she was an agency nurse and had not received guidance during orientation on how to handle medication administration if a resident was out at dialysis. Nurse #3 stated she asked a facility nurse for guidance and was told it was okay not to administer medication if a resident was out of the facility at dialysis. Nurse #3 stated she did not recall who the nurse was that she spoke to on 07/29/15. Nurse #3 stated she did not call the physician of Resident #108 or notify management nursing staff about the missed medication for Resident #108 on 07/29/15.</p> <p>On 08/19/15 at 4:30 PM the physician of Resident #108 noted Resident #108 came to the facility in a compromised condition and was very sick. The physician stated he did not remember being called about any concerns related to medication administration for Resident #108. The physician noted typically staff would notify him about medications for residents on dialysis so administration times could be adjusted; especially around the time of day the resident went to dialysis. The physician stated missed medications would have to be reviewed on an individual basis and that dialysis staff might have</p>	{F 333}			

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{F 333}	<p>Continued From page 37</p> <p>given the facility guidance as part of managing the resident's care.</p> <p>On 08/20/15 at 11:30 AM the manager of the dialysis center (where Resident #108 went for dialysis treatments) reported they never give guidance to a facility about medication administration and would anticipate medications would be administered as ordered by the resident's physician.</p> <p>On 08/20/15 at 3:15 PM the Director of Nursing (DON) stated if a resident is not in the facility when a medication is due to be administered it should be held and the physician would be called for guidance on administration when the resident returned. The DON stated for residents that go out of the facility on a regular basis, like a dialysis resident, nursing staff should speak to the physician about ordering medication before or after dialysis. The DON stated orientation was given to agency nurses but wasn't sure if specific guidance was provided about medication administration for residents receiving dialysis. The DON stated she had not been asked about medication administration for Resident #108 and would have expected this to be brought to someone's attention.</p> <p>2. Resident #69 was admitted to the facility on 01/22/15 with diagnoses including ankle fractures, diabetes, pressure ulcers, and end stage renal disease. Resident #69 went to dialysis Mondays, Wednesdays and Fridays.</p> <p>The quarterly Minimum Data Set dated 06/29/15 coded Resident #69 with intact cognition (scoring a 15 out of 15 on the Brief Interview for Mental</p>	{F 333}			

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{F 333}	<p>Continued From page 38</p> <p>Status) and receiving dialysis services.</p> <p>Review of the physician orders for August 2015 revealed Resident #69 was ordered the following three times a day:</p> <ul style="list-style-type: none"> <li>*Renvela (a binder to keep calcium in the body) 800 milligrams (mg) give 2 tabs with meals for elevated phosphorous; and</li> <li>*Metoclopramide HCl 5 mg before meals and bedtime for gastroesophageal reflux.</li> </ul> <p>Review of the Medication Administration Records (MAR) for August 2015 revealed missed medications as follows:</p> <ul style="list-style-type: none"> <li>*Renvela scheduled for 12:00 PM was missed Wednesday 08/05/15 for being on leave; on Friday 08/07/15 for "other" reason; on Friday 08/14/15 for being on leave; and on Monday 08/17/15 for being on leave.</li> <li>*Metoclopramide HCl scheduled for 11:30 AM was missed Wednesday 08/05/15 for being on leave; on Friday 08/07/15 for "other" reason; on Friday 08/14/15 for being on leave; and on Monday 08/17/15 for being on leave.</li> </ul> <p>On 08/19/15 at 10:54 AM, Resident #69 stated she did not receive her medications on Monday before going to dialysis.</p> <p>On 08/19/15 at 1:28 PM Nurse #3, who worked Friday 08/14/15, stated during interview that she tried to give Resident #69 her medications before she left for dialysis but sometimes she did not get to her in time. She stated that she marked the MAR that she was unavailable for the medications and passed it on to second shift nurses. She stated she did not inform the physician.</p>	{F 333}			

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{F 333}	<p>Continued From page 39</p> <p>On 08/19/15 at 1:45 PM, Nurse #2, who worked Friday 08/07/15, was interviewed and stated that she would mark the MAR with a "7" (meaning other) if Resident #69 was at dialysis by the time she was administering the noon medications. She stated that when that occurred, she did not report it to the physician but did report it to the oncoming nurse. She further stated she had not received any training regarding how to handle the scheduled medications if the resident was at dialysis.</p> <p>On 08/19/15 at 3:12 PM a phone interview was conducted with Nurse #7, who worked Wednesday 08/05/15. She stated that if a resident was at dialysis at the time a medication was due to be given, she would code that the resident was on leave on the MAR. She stated she was not trained on what to do if a medication was ordered at the time a resident was at dialysis. She did not inform the physician as she was not instructed to do so. Nurse #7 further stated that since she always went to dialysis three times a week at the same time Monday, Wednesday and Friday, everyone knew she did not receive the scheduled medications. She continued saying that there were no extraneous orders to hold the medication or call the doctor.</p> <p>On 08/19/15 at 4:17 PM a phone interview was held with the attending physician. The physician stated that normally when a resident was at dialysis during a medication time, the staff called him to obtain a clarification or time change for the medication. He further stated that the medications missed during the 3 dialysis days would not be a hardship on the resident.</p> <p>A phone interview with Nurse #6, who worked</p>	{F 333}			



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{F 333}	<p>Continued From page 40</p> <p>Monday 08/17/15, was conducted. Nurse #6 stated that Resident #69 had already left for dialysis when went to give her the medications on 08/17/15. She stated that was the first time she had that assignment and would have tried to give her medication before she left for dialysis, she stated she did not call the physician because the policy was that the physician did not have to be notified unless the medications were held twice.</p> <p>On 08/20/15 at 11:30 AM, the manager at the dialysis center was interviewed via phone and stated the dialysis center does not give guidance to the facility related to medications ordered by the facility's physician about what to do with the medications when the resident was at dialysis.</p> <p>Interview with the Director of Nursing (DON) on 08/20/15 at 3:14 PM revealed that for dialysis residents, staff should obtain a physician's order to give the medications before the resident goes to dialysis, after the resident returns from dialysis, or obtain a change in time for the medication set up with the dialysis schedule. DON stated she was unaware that Resident #69 was not receiving medications due to being at dialysis.</p> <p>3. Resident #14 was admitted to the facility on 11/03/2003. Diagnoses included epilepsy and anemia. Resident #14's quarterly Minimum Data Set (MDS) dated 07/07/15 indicated Resident #14 was cognitively intact, independent with activities of daily living and required supervision with ambulation.</p> <p>Resident #14's medical record was reviewed. Resident #14 was prescribed Carbamazepin 300 milligrams (mg) ER by mouth twice a day for epilepsy at 8:00 AM and 8:00 PM.</p>	{F 333}			

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{F 333}	Continued From page 41  Medication administration was observed. On 08/19/15 at 11:17 AM Resident #14 was administered a capsule of Carbamazepin 300 mg ER by mouth by Medication Technician (MT) #1.  A staff interview was conducted with MT #1 on 08/19/15 at 11:30 AM. MT #1 reported the facility was running behind on medication administration due to staffing concerns and affirmed the dose of Carbamazepin 300 mg ER administered to Resident #14 was Resident #14's dose scheduled at 8:00 AM.  The Director of Nursing (DON) was interviewed on 08/20/15 at 4:23 PM. The DON verbalized it was her expectation medications be administered within 1 hour of the scheduled time.	{F 333}			
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and resident and staff interviews, the facility administration failed to effectively manage and provide oversight in the areas of treatment to pressure sores (Resident #69) and for diabetic ulcer care (Resident #111) for 2 of 4 residents sampled for wound care.	{F 490}	F490  Resident # 69 ankle ring was placed on left leg while in bed on 8/20/15. Measurements of resident's wounds were obtained from wound doctor as of 8/18/15. Treatment will be performed before leaving for dialysis and in the	9/24/15	

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{F 490}	<p>Continued From page 42</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>F314: Based on observations, record review, resident interview and staff interviews, the facility failed to implement interventions including weekly skin sweeps, treatments as ordered, offloading pressure ulcers, and providing ordered yogurt snacks to promote the healing of pressure ulcers.</p> <p>F309: Based on medical record review, observations and staff and resident interviews, the facility failed to measure and treat a diabetic foot ulcer for 1 of 4 sampled residents reviewed for wound care.</p> <p>Interview with the Director of Nursing (DON) on 08/20/15 at 2:16 PM revealed that she was responsible for ensuring compliance with the plan of correction for wound care. She explained she randomly pulled the Treatment Administration Records (TAR) for residents she identified as having wounds. If there were blanks in the Tars she would ask the nurses if the treatments were completed. She stated she did not check on every blank noted in the TAR to ensure all treatments were being completed as ordered. She stated she tried to look to ensure all interventions were in place but did not look at all the interventions which were ordered to ensure all were in place. She developed a personal worksheet that listed the residents with wounds and their treatments. Reviewing these with the DON revealed the list of resident with ulcers was incomplete and the listed treatments were not up to date. Per the DON, the weekly at risk meetings did not include a review of each resident with a wound as there was not time to</p>	{F 490}	<p>evening after return.</p> <p>All residents have the potential to be affected.</p> <p>An audit of all residents receiving wound treatments will be reviewed for completion of treatments. Treatment nurse will audit all residents with pressure relieving interventions to ensure interventions are in place.</p> <p>The Director of Nursing/Designee will educate nursing staff on Golden Living wound care guidelines. New hires, permanent and temporary, will be educated on Golden Living wound care guidelines during orientation.</p> <p>Education addressing wound treatment will be provided by area wound center to nursing staff</p> <p>The Director of Nursing/Designee will review all residents with wounds during weekly At Risk meetings. The Director of Nursing/Designee will audit residents to ensure care plan interventions are in place weekly x 4weeks, then monthly.</p> <p>The audits will be reported monthly to Quality Assurance Performance Improvement committee (QAPI) x 3 months then QAPI will determine if further actions to be taken.</p> <p>F309</p> <p>Resident #111 had treatment put in place</p>		

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{F 490}	Continued From page 43 review everything that needed to be reviewed. She acknowledged there were still problems with the facilities wound care but they had hired a wound care nurse who just started 2 weeks ago to assist with the correction process.  Interview with the Administrator on 08/20/15 revealed he had only been in the facility a few weeks and was still getting acclimated to the facility.	{F 490}	on 8/20/15. Wound was measured by DNS on 8/20/15.  All residents with wounds have the potential to be affected.  An audit of all residents with wounds will be completed to ensure treatments are in place and measurements recorded.  The Director of Clinical Education/Designee will provide education to wound nurse and license nursing staff on Golden Living Wound Care guidelines.  Education addressing wound treatment will be provided by area wound center to license nursing staff.  The Director of Nursing/Designee will review and audit all new admissions with wounds and newly identified skin issues during clinical startup. The Director of Clinical education/Designee will observe the license nurse completing wound care treatments weekly x4 weeks, then monthly. Audits of wound measurements will be completed weekly during At Risk Meeting.  The audits will be reported monthly Quality Assurance Performance Improvement (QAPI)Committee x 3 months then the QAPI Committee will determine if further actions to be taken.  The Exective Director/Administrator will monitor POCs for F 309 and F 314, and will report to the Quality Assurance	

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{F 490}	Continued From page 44	{F 490}			
{F 520} SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor</p>	{F 520}	<p>Performance Improvement (QAPI) Committee x 3 months, then as directed by the Committee.</p> <p>F520</p> <p>Refer to F157 for compliance, monitoring, auditing and QAPI process for resident's</p>	9/24/15	

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{F 520}	<p>Continued From page 45</p> <p>these interventions that the committee put into place in July of 2015. This was for 7 recited deficiencies which were originally cited in June of 2015 on a Recertification and complaint survey and subsequently recited in the August 2015 revisit and complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>The findings included:</p> <p>This tag is cross referenced to:</p> <p>1.a. F157: Based on medical record review and staff interview the facility failed to notify the physician of 1 of 2 sampled residents receiving dialysis treatments (Resident #108) of medications not administered as ordered.</p> <p>The facility was recited for F157 for failing to notify a physician of medications not being administered as ordered. F157 was originally cited during the recertification and complaint survey in June of 2015 for failure to notify a responsible party about a medication change.</p> <p>b. F246: Based on observations, record reviews, resident interview and staff interview, the facility failed to keep a call bell within the reach of 1 of 3 residents sampled for call bells being in reach. (Resident #44).</p> <p>The facility was recited for F246 for failing to keep a call bell within a resident's reach. F246 was originally cited during the recertification and complaint survey in June of 2015 for not keeping a resident's call bell within their reach.</p>	{F 520}	<p>#108.</p> <p>Refer to F246 for compliance, monitoring, auditing and QAPI process for resident's #44.</p> <p>Refer to F272 for compliance, monitoring, auditing and QAPI process for resident's #68</p> <p>Refer to F281 for compliance, monitoring, auditing and QAPI process for resident's #58, #69.</p> <p>Refer to F282 for compliance, monitoring, auditing and QAPI process for resident's #38.</p> <p>Refer to F309 for compliance, monitoring, auditing and QAPI process for residents #111</p> <p>Refer to F314 for compliance, monitoring, auditing and QAPI process for resident #69</p> <p>Refer to F333 for compliance, monitoring, auditing and QAPI process for resident #14</p> <p>The Field Services Clinical Director will re-educate the QAPI committee on Golden Living QAPI policy on identifying issues and systems of care, root cause analysis, and the implementation of the plan of correction.</p> <p>The QAPI committee will be provided education on Quality Assurance by an</p>		

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{F 520}	<p>Continued From page 46</p> <p>c. F272: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes, contributing factors and risk factors for 1 of 3 sampled residents reviewed for the most recent comprehensive Minimum Data Set (MDS). (Resident #68).</p> <p>The facility was recited for F272 for failing to comprehensively assess triggered areas of concern. F272 was originally cited during the recertification and complaint survey in June of 2015 for the CAAs not being comprehensive.</p> <p>d. F281: Based on observations, staff interviews, resident interview and record reviews, the facility failed to administer a physician ordered supplement to 1 of 2 residents (Resident #69) reviewed for dialysis and the facility failed to consult with a physician prior to administering a medication, left at bedside and outside of the prescribed administration, for 1 of 1 resident (Resident #58) reviewed who received intravenous medication.</p> <p>The facility was recited for F281 for failing to administer supplements and medications per physician orders. F281 was originally cited during the recertification and complaint survey in June of 2015 for failure to clarify a method of medication administration and a correct dosage of medication ordered.</p> <p>e. F309: Based on medical record review, observations and staff and resident interviews, the facility failed to measure and treat a diabetic foot ulcer for 1 of 4 sampled residents reviewed for wound care. (Resident #111).</p>	{F 520}	<p>area health education center.</p> <p>The QAPI Committee will randomly audit 1 resident's record, care plan and orders to assist in identification of opportunities. The Field Services Clinical Director will audit all QAPI meetings for one year.</p>		

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{F 520}	<p>Continued From page 47</p> <p>The facility was recited for F309 failing to measure and treat a diabetic wound ulcer. F309 was originally cited during the recertification and complaint survey in June of 2015 for failure to monitor bowel irregularities.</p> <p>f. F314: Based on observations, record review, resident interview and staff interviews, the facility failed to implement interventions including weekly skin sweeps, treatments as ordered, offloading pressure ulcers, and providing ordered yogurt snacks to promote the healing of pressure ulcers for 1 of 4 residents sampled for pressure ulcers. (Resident #69).</p> <p>The facility was recited for F314 for failure to provide treatments, obtain weekly skin measurements and to provide physician ordered interventions to treat pressure sores. F314 was originally cited during the recertification and complaint survey in June of 2015 for failure to provide treatments as ordered and complete weekly skin assessments and change a wound vac device timely.</p> <p>g. F333: Based on observations, medical record review and staff and resident interviews the facility failed to administer medications to 2 of 2 sampled residents receiving dialysis treatments (Residents #69 and #108) and failed to administer an anti-seizure medication within the prescribed timeframe to 1 of 3 residents (Resident #58) observed during medication pass.</p> <p>The facility was recited for F333 for failure to administer significant medications to residents who go to dialysis and for failure to administer an anti-seizure medication timely. F333 was originally cited during the recertification and</p>	{F 520}			



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{F 520}	<p>Continued From page 48</p> <p>complaint survey in June of 2015 for failure to administer an anti-seizure medication timely to a resident.</p> <p>F490: Based on observations, medical record review and resident and staff interviews, the facility administration failed to effectively manage and provide oversight in the areas of treatment to pressure sores (Resident #69) and for diabetic ulcer care (Resident #111) for 1 of 4 residents sampled for wound care.</p> <p>The facility was recited for F490 for failure to manage and provide oversight for wound care. F490 was originally cited during the recertification and complaint survey in June of 2015 for failure to manage and provide oversight for pressure ulcer care and and infection control program.</p> <p>Interview on 08/20/15 at 5:30 PM with the Administrator and the Director of Nursing (DON) revealed the Quality assessment and Assurance Committee met monthly. Their action plans had ben driven by the previous recertification and complaint survey. The Administrator stated that there had been ad hoc meetings in the interim to address situations as they arose. The Administrator stated he was aware of concerns with medications which they addressed with retraining. The Administrator stated he had only been in the facility for a few weeks and still getting acclimated to the facility. The DON stated it was a work in progress to correct all the areas and acknowledged they still had areas which needed more work.</p>	{F 520}			