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	345119	A. BUILDING _____ B. WING _____	C 11/03/2017

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F 000	INITIAL COMMENTS No deficiency cited as a result of the complaint investigation on 11/3/17. Event ID #ZWKK11.	F 000		
F 221 SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	F 221		12/1/17

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

Electronically Signed | 11/22/2017

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 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility used a physical restraint without the presence of a medical symptom for 1 of 1 residents, (Resident #113). Findings included: Resident #113 was admitted to the facility on 10/27/14 with diagnoses that included vascular dementia with behavioral disturbance, Alzheimer's disease, repeated falls, abnormal posture, anxiety and generalized muscle weakness. Review of the November 2017 physician orders revealed the following restraint order: Soft belt with Velcro strap restraint while up in wheel chair related to unassisted transfer attempts secondary to dementia and cognitive impairment. The care plan for Resident #113 dated 10/16/17 was reviewed and included the following: "Focus - Use/Application of a physical restraint device for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility, physical aggression related to: unsteady gait, cognitive impairment, decreased/poor safety awareness, decreased strength, Hallucinations/Delusions, Impulsive behaviors, loss of balance, muscle weakness. Goal - Resident will not fall through next review; Resident will maintain upright position while in wheelchair position while in wheelchair through next review.	F 221	F 221 The process that led to this deficiency was the occupational therapist failed to communicate to the licensed nurse assigned to Resident #113 to obtain a physician's order to include the medical symptom related to the use of the pelvic restraint placed on Resident # 113. On 11/20/17, a physician's order was received by the Quality Improvement (QI) nurse for the pelvic restraint to include a medical symptom for Resident #113. On 11/22/17, a 100% audit of all residents with physical restraints to include Resident #113, was completed by the Corporate Consultant to ensure a physician's order was received to include a medical symptom related to the use of the physical restraint. On 11/22/17, a 100% audit all therapy notes and therapy evaluations for the past 5 months was initiated by the Corporate Consultant, to be completed by 12/1/17. This audit will ensure that all recommendations for residents to receive a physical restraint to include Resident #113 have a physician's order to include a medical symptom related to the use of the physical restraint. On 11/21/17, the occupational therapist was in-serviced by the Corporate Consultant on communicating with the	

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F 221	Continued From page 2 Interventions: * Discuss necessity of restraining device for resident with resident's family * Evaluate device for least restrictive, reduction, and/or discontinuation per facility protocol * Use safety devices (Pelvic holder for wheelchair positioning) when in wheelchair (Revised 6/28/17 by Nurse #2) * Monitor skin for signs or pressure areas * Remove device during supervised activities and reapply upon completion * Remove device during supervised mealtimes and reapply upon completion" Review of the resident's quarterly Minimum Data Set (MDS) dated 9/22/17 revealed that the resident had severely impaired cognition, was dependent for all activities of daily living and had a physical restraint used daily. The resident was observed on 10/31/17 at 5:05 PM to have on a pelvic restraint around her waist with straps tied behind the wheelchair. When she attempted to rise from the chair she could not. In an interview on 11/01/17 at 8:59 AM with the Director of Nursing she stated that it was her expectation that there be a medical symptom related to the use pelvic restraint in the resident's medical record. In an interview on 11/01/2017 at 9:23 AM with the Physical Therapy Program Director she stated that therapy had seen the resident in January, June and September of 2017 to assess the use of the restraint. She reported that each time therapy was referred to assess the resident it was because the resident had fallen. She said the	F 221	licensed nurse assigned to the resident receiving a new physical restraint so that a physician's order will be obtained to include a medical symptom related to the physical restraint. On 11/22/17, an in-service for 100% of all licensed nurses was initiated by the Staff Facilitator (SF) regarding when a resident receives a new physical restraint, a physician's order must be obtained to include a medical symptom related to the physical restraint. No licensed nurse will be allowed to work until the in-service is completed. All newly hired licensed nurses to include agency licensed nurses will be in-serviced during orientation by the Staff Facilitator (SF) regarding when a resident receives a new physical restraint, a physician's order must be obtained to include a medical symptom related to the physical restraint. All residents with therapy recommendations for physical restraints to include Resident #113 will be monitored by the Quality Improvement (QI) nurse, utilizing a Therapy to Nursing Communication QI audit tool to ensure a physician's order is obtained to include a medical symptom related to the physical restraint weekly for eight weeks, then monthly for one month. Any areas of deficiency identified will be immediately addressed by the QI nurse and/or SF to include retraining and obtaining a physician's order to include a medical symptom related to the physical restraint. The Director of Nursing (DON) will review	

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F 221	Continued From page 3 resident was in a self-release Velcro seat belt in January 2017 but that she had slid under it and that she also rose from the chair while the seatbelt was on, bringing the wheelchair up with her. She reported that in June 2017 she also had a chair alarm, anti-roll back and front anti-tippers in addition to the seatbelt on her wheelchair. She said the resident was getting skin tears on her legs from the wheelchair and was evaluated by Occupational Therapy who put her in the pelvic holder restraint. She reported that was the only thing that therapy could come up with that would keep the resident's hips back in the chair to keep her from sliding forward and to achieve optimum positioning. She reported that due to the resident's petite body structure that she required a special Hemi Height (used for individuals who have a short stature) wheelchair. She said that the facility also tried a breakaway lap buddy and different chair cushions but because the resident's special wheelchair width was 16 inches and most appliances (including the lap buddy and cushions) were made for standard 18 inch chairs they would not work. She stated that in September 2017 therapy was asked to evaluate the restraint to determine if it could be removed. The Program Director reported that the facility had tried all the interventions listed in the state operations manual as suggestions for reducing or eliminating the use of a restraint such as providing restorative therapy, providing a low bed with a mat on the floor, using a device that monitors his/her attempts to arise, and providing 1:1 supervision and an assisted toileting program. She said that the resident did not have the cognition to use a call bell or a trapeze. She also said that ambulation with restorative had to be stopped because the resident could not follow simple commands and it was a matter of stand	F 221	and initial the Therapy to Nursing Communication QI audit tool for accuracy and completion weekly for twelve weeks. The DON will review and present the findings of the Therapy to Nursing Communication QI audit tools to the Executive QI committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

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F 221	Continued From page 4 and fall/catch.	F 221		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		12/1/17

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F 431	Continued From page 5 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to discard 2 of 2 open, undated, and partially empty Tuberculin Purified Protein Derivative (PPD) vials based on manufacturer's instructions. Findings included: The Manufacturer's Instructions showed in bold text, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." An observation of the Cardinal Medication Room refrigerator was conducted on 11/03/17 at 8:37 AM with Nurse Supervisor #1. There were 2 open, undated, and partially empty vials of Tuberculin PPD in the medication refrigerator. The boxes the vials were stored in did not show an opened date. In an interview on 11/03/17 at 8:39 AM Nurse	F 431	F 431 The process that led to this deficiency was the 11-7 shift Nurse #1 and 11-7 shift Nurse #2 failed to follow the manufacturer’s instructions for 2 vials of Tuberculin Purified Protein Derivative (PPD) as indicated by not dating the vials upon opening. On 11/3/17, the two opened, undated, and partially empty Tuberculin Purified Protein Derivative (PPD) vials were removed from the medication refrigerator in the Cardinal medication room and discarded the Registered Nurse (RN) Unit Manager. On 11/3/17, a 100% audit of all medication refrigerators, medication carts, and	

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F 431	Continued From page 6 Supervisor #1 stated the vials of Tuberculin PPD should have been dated when first opened. She indicated that since there was no way to tell when the vials of Tuberculin PPD had been opened, they could not be used and would need to be discarded. In an interview on 11/03/17 at 11:09 AM the Consultant Pharmacist indicated it was her expectation that the manufacturer's instructions for medications be followed. She indicated the Tuberculin PPD was only good for 30 days after opening and if a vial was open and was not dated it should be discarded and not used. In an interview on 11/03/17 at 11:22 AM the Director of Nursing (DON) stated it was her expectation that nurses date vials of medications when they opened them.	F 431	medication rooms was completed by the RN Unit Manager and the Staff Facilitator (SF) to ensure the manufacturer's instructions for all medications to include PPD vials were being followed to include to date when open. The Cardinal medication room refrigerator was included in the audit. All opened medications to include PPD vials that the manufacturer's instructions were not followed to include date when opened, were immediately removed from the medication refrigerator, cart, and/or medication room, discarded, and reordered by the RN Unit Manager and the SF on 11/3/17. On 11/22/17, an in-service was initiated by the SF for 100% of all licensed nurses to include the 11-7 shift Nurse #1 and 11-7 shift Nurse #2 regarding following the manufacturer's instructions to include dating medications to include PPD vials upon opening, to be completed by 12/1/17. All newly hired licensed nurses to include agency licensed nurses will be in-serviced during orientation by the SF regarding following the manufacturer's instructions to include dating medications to include PPD vials upon opening. All medication refrigerators, medication carts, and medication rooms will be audited by the RN Unit Manager, SF, Quality Improvement (QI) nurse, and RN Supervisor weekly for 8 weeks, then monthly for 1 month to ensure all medications manufacturer's instructions are being followed utilizing a Medication Manufacturer's Instruction QI audit tool.	

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F 431	Continued From page 7	F 431	The audit will include looking at PPDs and medications that the manufacturer's instructions requires to date when open. Any areas of concerns identified will be immediately addressed by the RN Unit Manager, SF, Quality Improvement (QI) nurse, and RN Supervisor to include staff retraining, and removing, discarding and reordering identified medications that the manufacturer's medications were not followed to include opened and undated refrigerated medications. The Director of Nursing (DON) will review and initial the Medication Manufacturer's Instruction QI audit tool for completion and accuracy weekly for 12 weeks. The DON will review and present the findings of the Medication Manufacturer's Instruction QI audit tools to the Executive QI committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		12/1/17

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F 520	Continued From page 8 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to dating stored medications which resulted in a repeat deficiency at F431. The re-citing of F431 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program.	F 520	F 520 The process that led to this deficiency was staff failed to follow established policy on medication storage to include dating stored medications based on the manufacturer's instructions and the facility Quality Improvement (QI) process.	

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F 520	Continued From page 9 Findings included: This tag is cross-referenced to: F431: Medication Storage: Based on observation, record review and staff interviews the facility failed to discard 2 of 2 open, undated, and partially empty Tuberculin Purified Protein Derivative (PPD) vials based on manufacturer's instructions. Review of the facility's survey history revealed F431 was cited during the facility's 12/14/16 annual recertification survey, and was re-cited during the current 11/03/17 annual recertification survey. In an interview on 11/03/17 at 12:30 PM the Administrator stated the deficiency had probably reappeared because the facility had not been robust enough in its approach to monitoring the overall deficiency.	F 520	On 11/22/17, the Administrator, Director of Nursing (DON), and Quality Improvement (QI) nurse were educated by the Corporate Consultant on the QI process to include implementation of action plans, monitoring tools, the evaluation of the QI process, and modification and correction if needed to prevent the recurrence of deficient practice to include for dating stored medication based on manufacturer’s instructions. On 11/22/17, the Administrator, DON, and QI nurse were educated by the Corporate Consultant on the Quality Assessment (QA) process to include sustaining an effective QA program, identifying issues that warrant development, and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved. The Corporate Consultant completed a 100% audit on 11/22/17 of previous citations and action plans within the past year to include dating stored medication based on manufacturer’s instructions to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by the DON on 12/1/17 for any concerns identified. All data collected for identified areas of concerns to include dating stored medication based on manufacturer’s instructions will be taken to the Quality Assurance (QA) committee for review monthly for 3 months by the DON. The	

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F 520	Continued From page 10	F 520	Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance (QA) committee will be documented monthly at each meeting by the QI nurse. The Corporate Consultant will ensure the facility is maintaining an effective QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include medication storage to include dating stored medications based on the manufacturer's instructions and all current citations and QI plans are followed and maintained Quarterly x2. The Corporate Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern. The results of the monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive QI committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	