

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

PRINTED: 07/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2019
NAME OF PROVIDER OR SUPPLIER ELIZABETH CITY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909		
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E 000	Initial Comments	E 000			
F 578 SS=D	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she</p>	F 578		7/18/19	

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

TITLE

(X6) DATE

Electronically Signed

07/10/2019

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 578	<p>Continued From page 1</p> <p>has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to have advanced directive documents accessible to the staff to determine a resident's or family's wishes in the event of a cardiac and/or pulmonary arrest for 3 of 32 residents reviewed for advanced directives (Resident #79, #223, and #64). The findings included:</p> <p>On 6/24/19 at 3:15 PM an interview was conducted with the Assistant Director of Nursing (ADON) regarding advanced directives. The ADON stated they no longer had paper charts and used the electronic medical record instead. The ADON stated on admission to the facility the admission coordinator would speak with the resident or the responsible party (RP) to see what their wishes were and initiate a MOST (Medical Order for Scope of Treatment) form. A MOST form is a document that allows the resident and/or the RP to decide the scope of treatment to be provided by the facility in case of a medical emergency. Section A allows the resident/RP to select if their wish is for the staff to attempt resuscitation in the event of cardiac arrest and/or respiratory arrest or NOT to attempt resuscitation if this occurs. The ADON stated if the resident/RP</p>	F 578	<p>Advance Directives for resident #79, #223 and #64 were corrected on 6/26/19 by the Social Service Director and Admission Coordinator.</p> <p>A one hundred percent audit of all active residents was conducted on 6/26/19 by the Social Service Director and Medical Records Clerk to ensure the chart accurately reflected a Golden Rod, or MOST form for those residents who are Do Not Resuscitate, and placed in the binder labeled Advance Directives at the Nurses' station.</p> <p>Any resident who did not have a Golden Rod or MOST form completed for their desire of Do Not Resuscitate was completed on 7/12/19 by the Social Service Director.</p> <p>An In-service was completed on 6/27/19 by the Regional Operations Manager with Social Service Director, Admission Director, Marketing Director, Director of Nursing, Unit Managers to obtain these documents on admission and to re assess</p>		

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F 578	<p>Continued From page 2</p> <p>wished a DNR (Do Not Resuscitate), the physician was contacted for a 72 hour DNR order until the appropriate paperwork could be completed and the MOST form was put in a book labeled Advanced Directives at the nurse's station. The ADON continued and stated if a resident had a cardiac and/or pulmonary arrest, the Advanced Directive Book would be referenced by the staff to see what the resident's/RP's wishes were. The ADON further stated if the resident did not have an advanced directive the resident would be treated as a full code (attempt resuscitation efforts).</p> <p>1. Resident #79 was admitted to the facility on 5/17/19 and had a diagnosis of gastro-intestinal bleeding, chronic duodenal ulcer, bradycardia (slow heart rate), cardiac pacemaker and diabetes mellitus.</p> <p>Review of the computerized clinical record for Resident #79 revealed no physician's order or other information regarding an advanced directive. On 6/24/19 at 3:15 PM the Advanced Directive Book did not contain a MOST form or any advanced directive for Resident #79.</p> <p>On 6/25/19 at 4:01 PM, the ADON provided a Do Not Resuscitate (DNR) form and stated the resident went to the hospital and upon re-admission the DNR form did not get put back in the Advanced Directive Book and the form was in medical records.</p> <p>According to the clinical record, Resident #79 was last discharged to the hospital on 5/12/19 and re-admitted to the facility on 5/17/19.</p> <p>On 6/27/19 at 11:46 AM the Director of Nursing</p>	F 578	<p>at minimum of quarterly with the Resident, Resident Representative or Power of Attorney.</p> <p>The Director of Nursing, Assistant Director of Nursing, Unit Managers, Nurse Supervisor will review all new admissions, residents who return from a hospital stay, or outside appointment five times a week for four weeks, then three times a week for four weeks then weekly for one month during clinical meeting to ensure Advance Directive documents are accessible to the staff to determine a resident's or family's wishes in the event of a cardiac and/or pulmonary arrest. The Medical Records Director will audit all active residents weekly for eight weeks for advanced directive documents in the residents medical record and then monthly for one month.</p> <p>Advance Directive Accessibility Audit results will be reviewed in the Quality Assurance Process Improvement (QAPI) meeting monthly for three months for compliance.</p>		

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F 578	<p>Continued From page 3</p> <p>(DON) stated in an interview the advanced directive form should have been in the Advanced Directives Book. The DON further stated the nurses on the hall should ensure the advanced directive was put back in the book when re-admitted from the hospital.</p> <p>2. Resident #223 was admitted to the facility on 6/23/19 and had a diagnosis of heat exhaustion, hypertension, diabetes mellitus and dementia.</p> <p>Review of the computerized clinical record for Resident #223 revealed no physician's order or other information regarding an advanced directive. On 6/25/19 at 3:16 PM the Advanced Directive Book did not contain a MOST form or any advanced directive for Resident #223.</p> <p>On 6/25/19 at 3:30 PM the Assistant Director of Nursing (ADON) provided a MOST form for Resident #223 that noted to Attempt CPR (Cardio-pulmonary resuscitation)-Full scope of treatment. The ADON stated the form needed a physician's signature.</p> <p>On 6/27/19 at 11:46 AM the Director of Nursing stated in an interview the advanced directive should have been in the Advanced Directive Book.</p> <p>3. Resident #64 was admitted to the facility on 8/5/18 and had a diagnosis of diabetes mellitus, cerebrovascular accident (stroke), dementia, dysphagia and adult failure to thrive.</p> <p>Review of the electronic medical record revealed no physician's orders or other information regarding an advanced directive for Resident</p>	F 578			

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F 578	Continued From page 4 #64. On 6/24/19 at 3:16 PM there was no information found in the Advanced Directive Book for Resident #64 to indicate the resident's/RP's wishes in the event of a cardiac and/or respiratory arrest for Resident #64. On 6/26/19 at 1:54 PM the Assistant Director of Nursing (ADON) provided a form that noted the resident was a Full Code. When asked why the form was not in the Advanced Directive Book, the ADON stated she had done an audit and would get it in the book today. According to the clinical record, Resident #64 had been discharged to the hospital on 3/15/19 and re-admitted to the facility on 3/29/19. The resident was also discharged to the hospital on 5/11/19 and re-admitted to the facility on 5/16/19. On 6/27/19 at 11:46 AM the Director of Nursing (DON) stated the advanced directives should have been in the Advanced Directive Book. The DON further stated the resident had been out to the hospital several times and the form did not get put back in the book. The DON continued and stated the nurses on the hall should ensure the advanced directive was put back in the book when re-admitted from the hospital.	F 578			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the Minimum Data Set	F 641	Modifications of Minimum Data Set (MDS) for Residents #77,#131 and #103	7/18/19	

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F 641	<p>Continued From page 5</p> <p>(MDS) assessment accurately in the areas of Pre-admission screening and resident review (Resident #77), discharge (Resident #131) and unnecessary medications (Resident #103) for 3 of 37 residents reviewed.</p> <p>The findings included:</p> <p>1. Resident #77 was admitted to the facility on 2/6/2018 with diagnoses to include psychosis and paranoid schizophrenia.</p> <p>Resident #77's Level 2 Pre-admission Screening and Resident Review (PASARR) was dated 11/21/2013.</p> <p>Resident #77's annual Minimum Data Set (MDS) assessment dated 3/13/2019 Section A1500 was coded negative for level 2 PASARR determination.</p> <p>On 6/26/2019 at 8:14 AM, an interview was conducted with the MDS nurse #1 who stated the PASARR question was not coded for a level 2 and that was an error.</p> <p>On 6/27/2019 at 10:45 AM, an interview was conducted with the Administrator who stated he expected the MDS to be coded accurately.</p> <p>2. Resident #131 was admitted to the facility 12/24/2018 with diagnoses of fractured femur, history of falls, and difficulty walking.</p> <p>Resident #131's Discharge Minimum Data Set (MDS) assessment dated 3/31/2019 Section A2100, coded the resident was discharged to an acute hospital.</p>	F 641	<p>to correct errors were completed by the MDS nurse on 7/11/19.</p> <p>A one hundred percent audit of Section A and Section I for all active resident on their last MDS assessment was conducted by the MDS Nurse Coordinator and MDS Nurse was completed on 7/10/19 and any discrepancies were corrected with a modification of the assessment.</p> <p>MDS Nurse Coordinator and MDS Nurse was in-serviced on completing the Minimum Data Set (MDS) accurately to reflect the resident on 7/1/19 by the Regional Reimbursement Manager.</p> <p>The Regional Reimbursement Manager will review five Minimum Data Set (MDS) assessments and correlating documentation for accuracy weekly for four weeks, then two Minimum Data Sets (MDS) assessments and correlating documentation weekly for four weeks, then five Minimum Data Set (MDS) assessment and correlating documentation for 1 month.</p> <p>Results of the MDS audit will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting monthly for 3 months for compliance.</p>		

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F 641	<p>Continued From page 6</p> <p>A nurse progress note dated 3/31/2019 read: resident was discharge home with responsible party. The Physician was in to talk with the family and resident. Medications were sent home with the family and discharged papers were signed.</p> <p>On 6/25/2019 at 2:41 PM, an interview was conducted with Nurse #4, who discharged Resident #131. The nurse stated Resident #131 was discharged to home on 3/31/2019 with her family.</p> <p>On 6/26/2019 at 8:29 AM an interview was conducted with the MDS nurse #2 who stated resident #131 was discharged to home, not the hospital and the MDS was coded in error.</p> <p>On 6/27/2019 at 10:45 AM, an interview was conducted with the Administrator who stated he expected the MDS to be coded accurately.</p> <p>3. Resident #103 was originally admitted to the facility on 12/7/18, with diagnoses including Parkinsons' Disease, Anxiety Disorder and Major Depressive Disorder. According to the most recent Quarterly Minimum Data Set (MDS) dated 5/28/19, Resident #103 was cognitively impaired and required extensive to total assistance in most areas of activities of daily living. Resident #103 was coded as receiving antipsychotic, antidepressant and antianxiety medications during the last seven days of the look back period. Section I of the MDS revealed Resident #103 was coded for Non-Alzheimer's, Dementia, Anxiety, Parkinsons Disease and Depression. However, Resident #103 was not coded for psychosis.</p>	F 641			

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F 641	<p>Continued From page 7</p> <p>Review of Resident #103's Care Plan dated 6/19/19, read in part, "Mood State: Resident received antianxiety medication related to anxiety disorder and Parkinson's disease." Interventions included: Assess if resident/mood symptoms present a danger to the resident and/or others."</p> <p>Review of Resident #103's most recent medication orders revealed she was receiving Nuplacid (pimavanserin) 34mg. 1 capsule oral, 1 mg. by mouth every day for psychosis related to Parkinsons Disease dated 4/2/19, Pristig (desvenlafaxine succinate) tablet extended release 24hours, 50 mgs. 1 mg. oral once daily and Seroquel (Quetiapine) 50 mgs. 1 tablet by mouth every 8 hrs. twice daily for psychosis/hallucinations related to Parkinsons Disease, started 2/19/19.</p> <p>Review of Resident #103's psychiatric evaluations from 1/30/19 through 6/13/19 revealed, with adjustments the resident received Seroquel for psychosis related to parkinsons disease. Resident #103 also received Nuplacid with adjustments for psychosis related to parkinsons disease which started on 4/2/19.</p> <p>During an interview with MDS Nurse #1 and MDS Nurse #2 on 6/26/19 at 2:36 PM, MDS Nurse #1 said it was an error. She stated the psychiatric consult was scanned into the system and sent to medical records. She stated they review orders during morning meetings and if there were changes they would let them know.</p> <p>During another interview on 6/26/19 at 3:30 PM, MDS Nurse #2, stated the reason they did not code the MDS for psychosis related to Parkinsons was because there was not a code</p>	F 641			

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F 641	Continued From page 8 for psychosis related to Parkinsons on the MDS. During an interview on 6/27/19 at 11:23 AM, the Director of Nursing (DON) stated in regard to coding the MDS that her expectation was for the MDS to be accurate. She stated the MDS should have been coded if there was the ability to code it. During an interview on 6/27/19 at 12:10 PM in regard to coding the MDS, the Administrator revealed his expectation was that the MDS should be coded correctly.	F 641			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		7/18/19	

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F 656	<p>Continued From page 9</p> <p>provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to care plan psychotropic medications for 3 of 5 residents (Resident #2, #76 and #103) reviewed for unnecessary medications, and failed to care plan positioning aides for 1 of 4 resident (#124) reviewed for positioning/range of motion.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Resident #2 was admitted to the facility on 8/16/2018 with diagnoses to include cognitive deficit, depression, anxiety, and bipolar disorder with behaviors. <p>Resident #2's quarterly Minimum Data Set (MDS) assessment dated 4/2/2019 revealed she received antipsychotic and antidepressant medications for 7 out of 7 days during the look back</p>	F 656	<p>Care Plan for resident #2, #76 and #103 was updated to reflect psychotropic medications and resident #124 was care planned for positioning aids on 6/26/19 by the MDS nurse.</p> <p>A one hundred percent audit on all active residents with psychotropic medications and positioning aides was conducted on 6/26/19 by the MDS Nurse Coordinator and the MDS Nurse. Any residents care plan that did not reflect this, was updated on 6/29/19.</p> <p>An In-service on care planning residents was conducted on 7/1/19 by the Regional Reimbursement Manager to the MDS Nurse Coordinator and the MDS Nurse.</p>		

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F 656	<p>Continued From page 10 period.</p> <p>Physician orders for Resident #2 included sertraline 200mg daily for depression, trazodone 50mg daily for depression, and Risperdal 0.5mg daily for bipolar disorder.</p> <p>Resident #2's Care Plan, last reviewed/ revised on 5/29/2019 revealed a problem of behavioral symptoms for a history of anxiety, and a problem for history of depression. There was no care plan to address adverse effects related to the use of psychotropic medications, and to include interventions to monitor and document behaviors.</p> <p>On 6/26/2019 at 3:12 PM, an interview was conducted with the MDS nurse #2. The MDS nurse stated she had anxiety and depression care planned but did not have antipsychotic medications care planned.</p> <p>On 6/27/2019 at 11:22 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected the psychotropic medications to be care planned.</p> <p>2. Resident #124 was admitted to the facility on 3/7/2019 with diagnoses to include stroke, neurologic neglect syndrome, and above the knee amputation left side.</p> <p>Resident # 124's Care plan dated 4/22/2019 noted a problem of risk for falls secondary to left sided hemiplegia and recent left sided above the knee amputation (AKA). An approach read: Occupational Therapy (OT) modified chair for positioning.</p>	F 656	<p>The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit ten care plans weekly for eight weeks for psychotropic medication and need for positioning aides and then five care plans monthly for one month.</p> <p>The Care Plan audits will be reviewed in the Quality Assurance Process Improvement (QAPI) monthly meeting times three months for compliance.</p>		

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F 656	<p>Continued From page 11</p> <p>OT notes dated 5/7/2019 discharged Resident #124 from OT with recommendations of reclining chair for safety with adaptations including head support, lateral support, pommel cushion; lateral support for safety and recommended up in supervised area.</p> <p>Resident #124's Minimum Data Set (MDS) quarterly assessment dated 5/27/2019 revealed his cognition to be intact. He required extensive assistance from staff for Activities of Daily Living (ADLs), and total assistance for transfers.</p> <p>On 6/27/2019 at 10:24 AM, an interview was conducted with MDS nurse #2 who stated the MDS nurses did not usually care plan the type of chair a resident used. The MDS nurse stated the positioning devices and chair would have been put in the care guide book for the nursing assistants to use, and not on the care plan.</p> <p>A review of Resident #124's care guide revealed lateral supports, and pommel cushion, but did not have neck support listed.</p> <p>On 6/27/2019 at 10:45 AM, an interview was conducted with the Director of Nursing (DON) who stated she would not expect the type of chair the resident was to use to be care planned but would expect the modifications to the chair to be care planned.</p> <p>3. Resident # 76 was admitted to the facility on 12/11/17 with diagnoses including cardiovascular accident with hemiplegia, congestive heart failure, cognitive communication deficit, schizoaffective disorder, depression, anxiety and diabetes</p>	F 656			

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F 656	<p>Continued From page 12 mellitus.</p> <p>Resident # 76's quarterly Minimum Data Set assessment dated 5/30/19 revealed she received antipsychotic and antianxiety medications for 7 out of 7 days during the look back period.</p> <p>A review of the physician's order dated 12/4/18 revealed an order for Rexulit 0.5 mg daily for schizoaffective disorder and Klonopin 0.5 mg daily for anxiety.</p> <p>Review of the care plan last revised on 6/19/19 revealed she was at risk for anxiety related to use of antianxiety medication. Staff were to provide medications as physician ordered and monitor her for signs and symptoms of drowsiness or ataxia. There was no care plan to address adverse effects related to the use of psychotropic medications, or to include interventions to monitor and document behaviors.</p> <p>During an interview on 6/26/19 at 3:12 PM the MDS nurse #2 stated psychotropic medications were under activities of daily living and she would begin making the care plans more specific for residents receiving antipsychotics medications.</p> <p>On 6/27/2019 at 11:22 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected the psychotropic medications to be care planned.</p> <p>4. Resident #103 was originally admitted to the facility on 12/7/18, with diagnoses including Parkinsons' Disease, Anxiety Disorder and Major Depressive Disorder. According to the most recent Quarterly Minimum Data Set (MDS) dated 5/28/19, Resident #103 was cognitively impaired and required extensive to total assistance in most</p>	F 656			

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F 656	<p>Continued From page 13</p> <p>areas of activities of daily living. Resident #103 was coded as receiving antipsychotic, antidepressant and anti-anxiety medications during the last seven days of the look back period.</p> <p>Review of Resident #103's Care Plan dated 6/19/19, read in part, "Mood State: Resident received anti-anxiety medication related to anxiety disorder and Parkinson's disease." Interventions included: Assess if resident/mood symptoms present a danger to the resident and/or others."Resident #103 was not care planned for antidepressant medication and antipsychotic medication.</p> <p>Review of Resident #103's most recent medication orders revealed she was receiving Nuplacid (pimavanserin) 34mg. 1 capsule oral, 1 mg. by mouth every day for psychosis related to Parkinson's Disease dated 4/2/19, Pristig (desvenlafaxine succinate) tablet extended release 24hours, 50 mgs. 1 mg. oral once daily and Seroquel (Quetiapine) 50 mgs. 1 tablet by mouth every 8 hrs. twice daily for psychosis/hallucinations related to Parkinson's Disease, started 2/19/19.</p> <p>Review of Resident #103's psychiatric evaluations from 1/30/19 through 6/13/19 revealed, with adjustments the resident received Seroquel for psychosis related to Parkinson's disease. Resident #103 also received Nuplacid with adjustments for psychosis related to Parkinson's disease which started on 4/2/19.</p> <p>During an interview with MDS Nurse #1 and MDS Nurse #2 on 6/26/19 at 2:36 PM, MDS Nurse #2 stated there was not a care plan for</p>	F 656			

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F 656	Continued From page 14 antidepressant but there was one for antianxiety. She stated she just missed both of them. During an interview on 6/27/19 at 11:23 AM, the Director of Nursing (DON) stated in regard to care plans, her expectation was that the resident be care planned for antipsychotic and antidepressant medications. During an interview on 6/27/19 at 12:10 PM in regard to care plans, the Administrator stated his expectation was that care plans should be corrected.	F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and family interviews the facility failed to position a neck support cushion under the neck for 1 of 4 residents (Resident #124) reviewed for positioning/range of motion. The findings included: Resident #124 was admitted to the facility on 3/7/2019 with diagnoses to include stroke, neurologic neglect syndrome, and above the	F 684	Resident #124 was reassessed by Physical Therapy on 6/26/19 for positioning in Geri Chair while up. The findings included an upgrade from the Geri Chair to a standard wheelchair and discontinued the head and lateral support. A one hundred percent audit of all residents that are bed bound, in wheelchairs or Geri Chairs were reviewed by the Rehab Director to assess further	7/18/19	

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F 684	<p>Continued From page 15 knee amputation left side.</p> <p>Resident # 124's Care Plan dated 4/22/2019 noted a problem of risk for falls secondary to left sided hemiplegia and recent left sided above the knee amputation (AKA). An approach read: Occupational Therapy (OT) modified chair for positioning.</p> <p>OT notes dated 5/7/2019 discharged Resident #124 from OT with recommendations that included head support.</p> <p>A Restorative Plan for Resident #124 revealed issues to be addressed included head support. This training given to staff was signed by the restorative aides (RA) and OT on 5/7/2019 and 5/8/2019.</p> <p>Resident #124's Minimum Data Set (MDS) quarterly assessment dated 5/27/2019 revealed his cognition to be intact. He required extensive assistance from staff for Activities of Daily Living (ADLs), and total assistance for transfers.</p> <p>On 6/24/2019 at 12:07 PM, an interview was conducted with Resident # 124's Responsible Party (RP). The RP was pulling up a pink neck support cushion with 2 bolsters that fit on either side of the neck from behind Resident #124's back. The RP stated staff kept putting the neck support cushion under the resident's back and she had told them every time she came to the facility that it was to go under his head. The RP stated she had told multiple nursing assistants (NA) and nurses about positioning the pink neck support cushion correctly.</p> <p>An observation was conducted of Resident #124</p>	F 684	<p>evaluation for correct positioning and appropriate documentation on care guides on 7/11/19. Any resident found to have needs for improvement, the resident was re assessed by therapy and the Director of Nursing, Assistant Director of Nursing, Unit Managers or Nurses Supervisor shall update the care guide for that resident. For those more complex residents, pictures of positioning will be placed inside the residents closet to ensure proper positioning.</p> <p>The Rehab Director, Director of Nursing, Assistant Director of Nursing, Unit Managers and Nurse Supervisors were educated on communication and education of resident positioning devices, to include placement of treatment on the care guides and use of care guides or pictures for resident positioning needs on 7/1/19 by the Administrator.</p> <p>The Rehab Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Nurse Supervisors will audit ten resident weekly for four weeks, then five resident weekly for four weeks, the five residents monthly for one month for correct positioning and care guide documentation for accuracy of positioning needs.</p> <p>The positioning and care guide audits will be reviewed monthly in the Quality Assurance Process Improvement (QAPI) monthly for three months for compliance.</p>		

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F 684	<p>Continued From page 16</p> <p>on 6/25/2019 at 8:25 AM. Resident #124 was sitting up in the restorative dining room with the pink neck support under his upper back. The resident tilted his head back and had no support for either side of his neck.</p> <p>An observation was conducted of Resident #124 on 6/25/2019 at 9:30 AM as he was sitting in the television (TV) room. The resident was sitting in his reclining chair with the pink neck support under his upper back/shoulder area.</p> <p>An observation was conducted of Resident #124 on 6/25/2019 11:39 AM. The resident was in his room getting a shave by the nurse. The pink neck support was positioned behind his upper back.</p> <p>An observation was conducted of Resident #124 on 6/26/2019 at 7:52 AM in his room. The resident was sitting up in his reclining chair with the pink neck support cushion behind his upper back.</p> <p>An observation was conducted of Resident #124 on 6/26/20 at 10:29 AM in TV room. The pink neck support remained behind Resident #124's back.</p> <p>On 6/26/2019 at 12:14 PM, an interview was conducted with nursing assistant NA #2, after she transferred Resident #124 from his bed back to his chair. The pink neck support cushion was behind the resident's back after the transfer. The NA stated she thought the pink support was for his back.</p> <p>On 6/26/2019 at 8:34 AM, an interview was conducted with the Rehabilitation Manager, who</p>	F 684			

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F 684	<p>Continued From page 17</p> <p>stated Resident #124 was discharged from Occupational Therapy on 5/7/2019 because he was very weak and needed neck support and lateral trunk support while up in his chair. The Rehab Manager stated floor staff would have been educated on the positioning devices.</p> <p>On 6/26/2019 at 12:30 PM, an interview was conducted with Unit Manager #1 who stated OT recommendations were written in the residents' care guide, and therapy was to educate staff on the recommendations. The Unit Manager stated she did not know why the neck support was not listed on the care guide.</p> <p>On 6/27/2019 at 11:42 AM, an interview was conducted with the restorative aide (RA) #1. The RA stated OT usually educated the 2 RAs, but the RAs did not get residents up daily, that was the duty of the floor NA.</p> <p>On 6/26/2019 at 2:34 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the Rehabilitation staff to educate floor staff on positioning devices. The DON stated she expected NAs to ask what a positioning device was for if they were uncertain, and for the devices to be listed on the care guide for the NAs to use as a reference.</p>	F 684			
F 759 SS=D	<p>Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced</p>	F 759		7/18/19	

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F 759	<p>Continued From page 18</p> <p>by: Based on observations, record review and staff interviews, the facility failed to have a medication error rate of 5 percent or less as evidenced by 3 medication errors out of 25 opportunities for a medication error rate of 12 percent for 2 of 7 residents observed during medication pass (Resident #66 and #30). The findings included:</p> <p>1. Resident #66 was admitted to the facility on 8/31/16 and had a diagnosis of glaucoma and pain. There was a physician's order dated 3/27/19 for Dorzolamide-Timolol 0.2% (percent)-0.5% (Cosopt), 1 drop to left eye twice a day and was scheduled on the electronic Medication Administration Record (e-MAR) for 8:30 AM. Cosopt is a medication used to treat glaucoma.</p> <p>On 6/26/19 at 7:58 AM, Nurse #1 was observed to prepare medications for Resident #66. The nurse removed a box from the medication cart that read: "Dorzolamide-Timolol (Cosopt) 0.2%-0.5%. Give 1 drop to left eye twice a day." The bottle of medication in the box read: "Combigan" on the bottle of eye drops. The nurse was observed to administer one drop of the Combigan in the left eye of Resident #66. Nurse #1 was observed to return to the medication cart and stated more medications had shown up on the eMAR to be given. One of the medications that had come up on the e-MAR read: Brimonidine-Timolol (Combigan) 0.2%-0.5%, 1 drop in both eyes twice a day and was scheduled for 9:00 AM. Combigan is also a medication used to treat glaucoma. The Nurse stated she would give the Brimonidine-Timolol (Combigan) eye drops to the resident after breakfast. The Nurse was asked to look at the bottle of eye drops she</p>	F 759	<p>Nurse #1, #2 and #3 were provided education on giving medications per MD orders, verifying medication accuracy and time administration directions on 7/11/19 by the Pharmacy Nurse Consultant.</p> <p>A one hundred percent audit of all eye drops to ensure medication was in correct packaging, application directions of all ointments was completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers on 7/10/19. Any incorrect labeling or storage of eye drops or questionable directions in the delivery of ointments or creams were corrected. An audit of the medication times was completed by the Unit Managers on 7/09/19. All resident's medication pass times were adjusted to allow for passing medications within one hour of their prescribed time.</p> <p>Nurses and Medication aides were in-serviced on verifying medication in boxes with medication ordered and verifying accuracy of ointment or cream orders to eliminate discrepancies in delivery, as well passing medications within one hour of their prescribed time by the Pharmacy Nurse Consultant on 7/11/19.</p> <p>The Director of Nursing, Assistant Director of Nursing, Unit Managers or Nursing Supervisor will audit for correct placement of medication in containers and clear directions on ointments and creams on each medication cart weekly for four</p>		

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F 759	<p>Continued From page 19</p> <p>administered to the left eye of Resident #66. The Nurse was observed to remove the bottle from the box and stated the bottle of medication was Combigan and she would need to administer a drop to the right eye as well. The Nurse stated she looked at the box and the directions on the box instead of looking at the bottle and did not realize she gave Brimonidine-Timolol (Combigan) eye drops instead of Dorzolamide-Timolol (Cosopt) eye drops.</p> <p>On 6/27/19 at 11:31 AM the Director of Nursing stated in an interview she expected the eye drops to be stored in the appropriate container and for the nurse to look at the order on the e-MAR and the bottle of eye drops to ensure the correct medication was being administered.</p> <p>2. Resident #30 was admitted to the facility on 8/23/18 and had a diagnosis of gastro-intestinal hemorrhage (bleeding).</p> <p>There was a physician's order dated 10/15/18 that read: Pantoprazole DR (Delayed Released) 40mg (milligrams) twice a day and was scheduled for 7:30 AM and 4:30 PM. The manufacturer's specifications noted the delayed released Pantoprazole (Protonix) could be given with or without food in the stomach. Protonix is a medication used to decrease the amount of acid in the stomach and for the treatment of stomach ulcers.</p> <p>On 6/26/19 at 9:45 AM, Nurse #2 was observed to prepare medications for Resident #30. The Nurse included Pantoprazole DR 40mg (milligrams) in the medications she administered to the resident.</p>	F 759	<p>weeks then three medication carts weekly for four weeks, the one medication cart for one month. Medication administration observations will be conducted on one nurse or Medication Aide per unit weekly for eight weeks then monthly for one month.</p> <p>Medication storage, accuracy of ointment and creams and medication pass audits will be reviewed in the Quality Assurance Process Improvement (QAPI) meeting monthly for three months.</p>		

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F 759	<p>Continued From page 20</p> <p>On 6/26/19 at 11:33 AM, Nurse #2 stated in an interview that sometimes the resident would come to her and she would give him his medication around 7:30 AM but she got behind this morning and did not get his medication to him within one hour of the scheduled time.</p> <p>On 6/27/19 at 11:33 AM, the Director of Nursing stated she expected medications to be given one hour before to one hour after the time the medication was scheduled to be given.</p> <p>3. Resident #66 was admitted to the facility on 8/31/16 and had a diagnosis of pain.</p> <p>There was a physician's order dated 3/27/19 that read: "Voltaren gel 1% (percent), 4 grams topical. Special Instructions: to each knee for pain. Four times a day" and was scheduled for 4:30 PM. Voltaren Gel is a medication used topically for arthritis and pain.</p> <p>On 6/26/19 at 3:55 PM, Nurse #3 was observed to prepare medications for Resident #66. The nurse measured out Voltaren gel 1% 4 grams and put in a medicine cup. The Nurse was observed to donn gloves and rub ½ of the medication in the cup to the right knee and the other half of the medication to the left knee.</p> <p>Nurse #3 stated in an interview on 6/26/19 at 4:00 PM, she had asked about the dosage of the Voltaren for Resident #66 in the past and was told to use a total of 4 grams. The Assistant Director of Nursing (ADON) joined the interview and stated she would need to clarify the order.</p>	F 759			

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F 759	Continued From page 21 On 6/26/19 at 4:55 PM the ADON stated she had clarified the Voltaren order for Resident #66 and the order was to apply 4 grams of Voltaren Gel to each knee. On 6/27/19 at 11:36 AM the Director of Nursing stated in an interview she would expect the nurse to follow the instructions and give medications as directed and if the order was not clear to clarify the order.	F 759			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		7/18/19	

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F 880	<p>Continued From page 22</p> <p>but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880			

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F 880	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, staff interviews and review of CDC (Centers for Disease Control) guidelines, the facility failed to properly clean a glucose meter after use for 1 of 1 resident observed during medication pass (Resident #21). The facility also failed to store individual glucose meters in a sanitary manner for 8 of 8 residents observed during blood sugar checks (Resident #58, #229, #95, #11, #52, #54, #28 and #17 and. The findings included:</p> <p>1. Resident #21 was admitted to the facility on 2/28/19 and had a diagnosis of diabetes mellitus. On 6/26/19 at 4:12 PM, Nurse #3 was observed to prepare medications for Resident #21. Nurse #3 was observed to take a glucose meter from the medication cart and enter the resident's room and did a finger stick blood sugar check using the glucometer from the medication cart. The nurse was observed to return to the medication cart where she placed the glucose meter on top of the medication cart. At this time the Nurse stated she cleaned the glucose meter between each resident. The Nurse further stated they were supposed to use the wipes in the container with a gold top but she used the one with the purple top. The nurse was observed to remove a wipe from the container with a purple top and wiped the glucose meter front and back and again front and back and laid on a tissue on the medication cart "to dry" and disposed of the wipe. The nurse was observed to clean the glucose meter for 30 seconds.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON) who stated she taught infection control in</p>	F 880	<p>Glucometers for resident #58,229,95,52,54,28 and 17 were removed from bedside drawers, cleaned using the gold top wipes, as per manufactures directions, allowed to dry and placed in sandwich containers. The glucometers and sandwich containers were labeled with the resident' name. The sandwich containers were placed back in bedside drawers. All glucometers were removed form medications cares on 6/26/19. Nurse #3 was educated on proper cleaning of the glucometer and individual use on m6/26/19 by the Assistant Director of Nursing. NA #1 was educated on the proper storage of glucometers in each resident drawer on 6/29/19 by the Assistant Director of Nursing.</p> <p>An audit of all residents with glucometers was conducted on 7/2/19 by the Central Supply Clerk for appropriate storage. All glucometers were placed in individual sandwich containers and labeled while placed in the resident top drawer of the bedside table. All glucometers ere removed from Nursing carts.</p> <p>An In-service was provided to all Licensed Nurses and Certified Nursing Assistant 2 on proper cleaning and storage of glucometers, and individual glucometers on 6/26/19 by the Assistant Director of Nursing.</p> <p>The Director of Nursing, Assistant</p>		

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F 880	<p>Continued From page 24</p> <p>the facility. The DON continued and stated the container of wipes with the purple top did not have bleach and should not be used to clean the glucose meter. The ADON continued and stated the wipes in the container with the gold top had bleach and should be used to clean the glucometer if used for multiple residents.</p> <p>On 6/26/19 at 4:55 PM a second interview was conducted with Nurse #3. At this time a container of wipes with a gold top was observed on the medication cart along with a container of wipes with a purple top. The Nurse stated she was trained to clean the glucose meter with the wipes in the container with the gold top. When asked why she used the wipes in the container with the purple top, the Nurse stated she did not know they had any gold top containers in the back. The Nurse stated she did not know how long she cleaned the glucose meter but she wiped it front and back two times.</p> <p>On 6/27/19 at 11:39 AM an interview was conducted with the Director of Nursing (DON). The DON stated the glucose meter should not have been on the medication cart and the staff should use the resident's individual glucose meter stored at the bedside. The DON continued and stated the glucose meters had been removed from the medication cart. The DON further stated if the staff need to clean a glucose meter, they should use the bleach wipes in the gold container and the glucose meter should be cleaned for 2 minutes.</p> <p>According to CDC guidelines: "Blood glucose meters dedicated for single-patient use should, ideally, be stored in the patient's room in a</p>	F 880	<p>Director of Nursing, Central Supply Clerk or Unit Managers will complete an audit three times a week for four weeks to ensure individual glucometers are in resident rooms and being used for residents. Then weekly for four weeks and then monthly for one month.</p> <p>The Director of Nursing, Assistant Director of Nursing or Unit Manager will conduct audits for observation of cleaning technique and proper placement of glucometers in the storage containers. This will done with four nurses and 1 medication aide weekly for four weeks, then two nurses and one medication aide weekly for four weeks, then two nurses and one medication aide monthly for one month.</p> <p>The audit results will be reviewed in the Quality Assessment Process Improvement (QAPI) meeting monthly for three months for compliance.</p>		

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F 880	<p>Continued From page 25</p> <p>manner that will protect against inadvertent use for additional patients and cross-contamination via contact with other meters or equipment. An evaluation of instrument storage areas in hospitals found that 20% (percent) of areas where blood glucose meters were stored were contaminated with blood. If the blood glucose meter becomes contaminated through inappropriate storage, subsequent patients could be exposed to infectious agents, even if the meter itself does not have direct patient contact."</p> <p>On 6/29/19 at 11:30 AM, an interview was conducted with Nursing Assistant (NA) #1. The NA stated she did all the blood sugars in the building before lunch and gave the results to the floor nurse when finished. The NA stated each resident had their own glucose meter in their room.</p> <p>1. Resident #58 was admitted to the facility on 3/12/18 and had a diagnosis of diabetes mellitus.</p> <p>On 6/26/19 at 11:40 AM, NA #1 was observed to do a finger stick blood sugar on Resident #58. After she checked the resident's blood sugar the NA returned the glucose meter to the drawer of the resident's beside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p>	F 880			

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F 880	<p>Continued From page 26</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p> <p>2. Resident #229 was admitted to the facility on 6/17/19 and had a diagnosis of diabetes mellitus.</p> <p>On 6/26/19 at 11:43 AM, NA #1 was observed to do a finger stick blood sugar on Resident #229. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p>	F 880			

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F 880	<p>Continued From page 27</p> <p>3. Resident #11 was admitted to the facility on 8/14/16 and had a diagnosis of diabetes mellitus.</p> <p>On 6/26/19 at 11:46 AM, NA #1 was observed to do a finger stick blood sugar on Resident #11. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p> <p>4. Resident #52 was admitted to the facility on 11/16/18 and had a diagnosis of diabetes mellitus.</p> <p>On 6/26/19 at 11:48 AM, NA #1 was observed to do a finger stick blood sugar on Resident #52. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p>	F 880			

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F 880	<p>Continued From page 28</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p> <p>5. Resident #54 was admitted to the facility on 12/2/16 and had a diagnosis of diabetes mellitus.</p> <p>On 6/26/19 at 11:52 AM, NA #1 was observed to do a finger stick blood sugar on Resident #54. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p>	F 880			

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F 880	<p>Continued From page 29</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p> <p>6. Resident #95 was admitted to the facility on 5/10/19 and had a diagnosis of diabetes mellitus. On 6/26/19 at 11:55 AM, NA #1 was observed to do a finger stick blood sugar on Resident #95. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p> <p>7. Resident #28 was admitted to the facility on</p>	F 880			

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F 880	<p>Continued From page 30</p> <p>5/19/17 and had a diagnosis of diabetes Mellitus.</p> <p>On 6/27/19 at 11:59 AM, NA #1 was observed to do a finger stick blood sugar on Resident #28. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p> <p>8. Resident #17 was admitted to the facility on 11/6/15 and had a diagnosis of diabetes mellitus.</p> <p>On 6/26/29 at 12:01 PM, NA #1 was observed to do a finger stick blood sugar on Resident #17. After the NA checked the blood sugar she put the glucose meter in the drawer of the resident's bedside table. The glucose meter was not stored in a bag or box of any kind.</p> <p>On 6/26/19 at 4:35 PM an interview was</p>	F 880			

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

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F 880	<p>Continued From page 31</p> <p>conducted with the Assistant Director of Nursing (ADON). The ADON stated she taught infection control to the staff in the facility. The ADON further stated the glucose meters in the resident's rooms should be stored in the box they came in or if the box was not usable they should be stored in a plastic container because sometimes there were spills in the drawers like peri-wash.</p> <p>On 6/27/19 at 11:39 AM the Director of Nursing (DON) stated in an interview she would expect the glucose meters to be stored in a zip lock bag or plastic container. The DON further stated the glucose meters were now stored in a plastic container as any blood on the meter could contaminate everything in the drawer.</p>	F 880			