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	345375	A. BUILDING _____ B. WING _____	C 09/12/2014

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SCOTLAND MANOR HEALTH CARE CENTER	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview the facility failed to notify the physician of a high Thyroid Stimulating Hormone	F 157	1. On 9/11/2014, the Medical Director increased resident #70 Synthroid to 75 micrograms by mouth daily. A follow up	10/17/14

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

Electronically Signed | 10/03/2014

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F 157	Continued From page 1 (TSH) level for 1of 6 residents reviewed for significant changes in condition. (Resident #70). Findings included: Resident #70 was admitted on 06/11/14 with a diagnosis of hypothyroidism. Review of a physician order dated 07/18/14 revealed a laboratory request for a TSH level. Review of a laboratory report faxed to the facility on 07/22/2014 revealed a blood collection date of 07/21/14 for a TSH level for Resident #70. The TSH result was "14.30" uIU/ml (one-millionth International Unit); the normal range read 0.45 - 4.5 uIU/ml and the test result was documented as "HIGH". Review of the facility fax transmission verification report dated 07/22/14 at 8:51am revealed that the facility faxed the TSH level results to the facility's Medical Director who was also Resident #70's medical doctor. Review of the Medical Director's fax back to the facility dated 07/23/14 at 9:34 am showed a note from the medical director to the facility written on the lab results as "What dose is synthroid (Levothyroxin)?" and signed by the Medical Director. Review of a facility fax face sheet dated 07/23/14 to the Medical Director from nurse #3 regarding Resident #70 revealed a remark by nurse #3 was, "Resident takes Levothyroxine 25mcg (micrograms) po (by mouth) daily." Review of Resident #70's medical record did not reveal any information from 07/22/14 through 09/10/14 indicating that the facility communicated with the medical director or any other person regarding the resident's 07/21/14 laboratory result of a "HIGH" TSH. Review of physician orders and review of the medication administration records (MAR) dated from 06/11/14 through 09/10/14 revealed that	F 157	levothyroxine level was ordered on 9/12/2014 with results faxed and called with the results on 9/18/2014. Results on 9/18/2014 for the TSH level were 8.910 (down from previous reading of 14.3) No new orders received following this reading. Follow up TSH in 6 weeks. During audit, it was noted that the lab had been ordered on 9/11/14 and drawn on 9/17/14. Interventions put into place to prevent this same occurrence from happening again: the lab book is brought to the Clinical White Board (CWB) meeting each morning to review labs drawn, results received, physician notification, family notification for abnormal labs and the review of any new orders received for changes. CWB Meeting is a meeting held each week day Monday through Friday to cover the previous days business to assist in improving resident care, improve communication, and follow up. Topics of discussion are: incidents/accidents, antibiotics, wounds, change of condition, weight loss, hydration, labs, Coumadin/PT/INR, Admissions, Discharges, Behaviors, Appointments, ABAQIS, RAIMax, Equipment, TB/Flu/Pneumonia, Education, Etc. Monday□s meeting will include discussion of Friday, Saturday and Sunday changes. 2. All residents are potentially at risk for alleged deficient practice. All lab orders will be taken by a licensed nurse and placed on the calendar in the lab book with follow up on the Clinical White Board (CWB). The lab book is brought to the	

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F 157	Continued From page 2 Levothyroxin 25 mcg tablet po daily was ordered upon admission on 06/11/14 and administered as ordered through 09/10/14. No changes in the Levothyroxin dosage were ordered. On 9/11/14 at 9:55 am an interview was conducted with the facility Director of Nursing (DON) who stated, "I expect that significant lab results should be faxed to the resident's physician and followed by a phone call to notify the physician of the lab results. If the physician does not respond to significant laboratory results then I expect the nurse to notify the physician again and document his response. I expect the 11pm - 7am shift nurses to review resident charts and check lab results to make sure significant lab results have been faxed, called to the physician and responded to by the physician. I expect the nurse to document and sign all communication. I do think that a TSH level that is 10 points higher than the normal range is significant and should have been called to the physician along with a fax." On 9/12/14 at 10:40 am, an interview with the facility Medical Director indicated that he became aware yesterday that the resident's TSH was high. He indicated that on 09/11/14 he adjusted the resident's Levothyroxin to 75mcgs po daily. He indicated that the TSH level was a concern, but not critical enough to administer intravenous Levothyroxin. The facility Medical Director indicated that the facility may have faxed him Resident #70's 07/21/14 elevated TSH results but he expected the nurses to call him to verbally report significant lab results in addition to a fax, especially if he has not responded to the facility within a 24-48 hour period of time.	F 157	CWB meeting each morning to review labs drawn, results received, physician notification, family notification for abnormal labs and the review of any new orders received for changes. Participants in the CWB are DON (Director of Nurses), ADON (Assistant Director of Nursing), SDC (Staff Development Coordinator or Nurse), MDS (Minimum Data Set Nurse), Unit Manager, Social Services, Dietary, and Wound or Treatment Nurse. 3. The DON (Director of Nursing) or ADON shall run the CWB meeting each weekday morning to include charts with new orders brought into the meeting to verify new orders are in place and/or appointments made (to include date and time). The DON or ADON shall check the written order in the chart and validate the order is completed and scheduled as needed. The charge nurse shall flag any new orders by the physician by raising the telephone order sheet to protrude from the top of the chart to signify follow up needed before end of shift. Additionally the night shift nurse shall review all charts for new orders and place a line on the last day of orders, date and sign as reviewed. This documentation will be kept in the medical record. Education was provided to all licensed nurses related to lab processes and procedures to include the following: Knowing where to transcribe lab orders, knowing where to document lab is completed, knowing that labs must be followed up on daily by clinical administration team during CWB Meeting, and knowing when to call in critical labs to	

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F 157	Continued From page 3	F 157	a Physician. This education will be completed by 10/17/14. This education will become part of the orientation process for all newly hired licensed nurses. 4. Monitoring shall be done by the DON or ADON as five charts five days per week day for two weeks, then five charts per week for four weeks, then five charts per month for three months. Audit results will be filed in the Plan of Correction binder held in the administrator□s office. The results will be brought to the QAPI meeting by the DON or the administrator and will be noted and reviewed in the monthly QAPI meeting minutes. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The QAPI Committee consists of the Administrator, the DON, SDC, MDS Coordinator, Admission Coordinator, Rehabilitation manager, Medical Director, Director of Social Services and Environmental Services.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		10/17/14

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F 279	Continued From page 4 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan that addressed vision impairment for 1 of 1 residents (Resident #61) reviewed for visual impairment. The findings included: Resident #61 was admitted to the facility on 4/25/14. Her diagnoses included acute psychosis, Diabetes Mellitus, hypertension, advanced dementia and primary open angle glaucoma (5/6/14). The Minimum Data Set (MDS) dated 7/22/14, a significant change MDS, revealed the resident was coded to have moderately impaired vision. The Care Area Assessment for this MDS triggered for visual function and was checked that this was addressed in the care plan. A review of the Care Plan revealed there was no care plan related to Resident #61's poor vision. A Weekly Summary sheet dated 4/29/14 present in the medical record revealed "vision severely impaired. No vision or sees only light, colors or shapes." An additional Weekly Summary sheet	F 279	1. Resident #61 is no longer in the facility. 2. All resident care plans were reviewed by the MDS nurse by 10/10/14 to determine they were consistent with the MDS triggers and CAA's. In regards to vision care plans, all residents that were triggered by Vision CAA's, were reviewed by 10/02/14. The MDS nurse completed education related to care plans, CAAs, MDS, and QM on July 15, 2014. Additionally, she has most recently completed training on MDS 3.0, MDS A-Z, and MDS 3.0 and Rugs 4 on 10/06/14. All education was initiated by Signature Healthcare's Clinical Reimbursement Specialist and conducted through SHCLearn, Signature's online education portal. This education has been added to the survey's POC book. 3. The MDS nurse or SDC will re-educate the floor nurses to put into place the initial	

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F 279	Continued From page 5 dated 5/6/14 documented the same information for vision and was signed by nurse #3. The medical record review revealed a referral form dated 5/6/14 for the eye doctor. The diagnosis was listed as primary open angle glaucoma and it included orders for 3 types of eye drops. In an interview with Nursing Assistant (NA) #3 on 9/11/14 at 9:15am she revealed Resident #61 had problems seeing and that was the reason the staff had to talk to her and tell her what they were going to do. During an interview with the DON on 9/11/14 at 2:47pm she stated Resident #61 did not see well when she first arrived at the facility. An interview with NA #11 on 9/11/14 at 3:13pm revealed she always had to tell Resident #61 what food was present on her tray. NA #11 stated the resident was not able to see when she first arrived at the facility. She added the resident could feed herself but had to be told what her food items were on the plate. During an interview with the DON on 9/12/14 she acknowledged that Resident #61 should have a care plan for her vision impairment.	F 279	care plan and how to update current care plans by 10/17/14. The MDS nurse will be present at the Clinical White Board meeting to identify any care plans needing to be updated. 4. Care plan changes or additions will be monitored 5 days a week for two weeks by the MDS coordinator. Monitoring will continue weekly for four weeks and monthly for three months. Results of this monitoring will be reported to the QAPI meeting monthly by the MDS nurse. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The QAPI Committee consists of the Administrator, the DON, SDC, MDS Coordinator, Admission Coordinator, Rehabilitation manager, Medical Director, Director of Social Services, and Environmental Services.	
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	F 309		10/17/14

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F 309	Continued From page 6 by: Based on record review, observation, resident and staff interview the facility failed to provide post-dialysis assessment in accordance with facility protocol for one of two residents that were sampled and received dialysis. (Resident #46) Findings included: The facility clinical guidelines titled "Dialysis-Monitoring the ESRD (End Stage Renal Disease) Resident" dated as effective 12/2010 included the following: "Access Care: · Residents who have ESRD will be provided appropriate clinical interventions based on their physician's orders. · Follow blood pressure monitoring according to the physician's orders (pre and post dialysis). · Check the access and document the findings each day upon return from the dialysis center to see if it is functioning. You can use your fingers and feel for a "buzzing" sensation, (this is called a thrill) or if you use your stethoscope you can listen over the access for a "bruit" . The "bruit" is the sound of blood rushing through the access. If the access is clotted call the physician." Resident #46 was originally admitted to the facility on 05/29/12. Diagnosis included End-stage Renal Disease. The last minimum data set (MDS) dated 07/19/14 indicated that resident #46 was cognitively intact. Diagnoses included End-stage Renal Disease, on dialysis. Resident #46's functional status was documented as limited assistance with one-person assist. The Care Area Assessment (CAA) triggered for potential complications related to hemodialysis. A physician order dated 08/30/13 read, "Assess	F 309	1. Resident #46 has his post dialysis documentation in place. This documentation will include assessment of dialysis site upon return from dialysis for bleeding, pain, redness, edema as well as access site for presence of bruit and thrill. Vital signs are recorded as well. 2. The DON, ADON or SDC will identify and review each resident on dialysis and that their record contains the correct documentation and is recorded on each resident□s chart that goes to dialysis. The record will contain assessment of dialysis site upon return from dialysis for bleeding, pain, redness, edema as well as access site for presence of bruit and thrill. Vital signs are recorded as well. 3. Licensed nurses will be re-educated by the DON or Staff Development Nurse by 10/17/14 on post dialysis prompt assessment of the dialysis access site. Each resident receiving dialysis treatment will have the correct dialysis documentation present and completed upon return from their dialysis visit. In addition, prompting has been added to EZ Mar (electronic medical record system) to insure vital signs, site access, and access appearance are recorded following the return from dialysis treatment on specified days. 4. All residents identified as receiving dialysis treatments shall have documentation of bleeding, pain, redness, edema, access site for presence of bruit	

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F 309	Continued From page 7 dialysis site for S/Sx (signs and symptoms) of infection, bleeding, pain, redness, swelling QHR (every hour) X6 (for six) hours S/P (status post) dialysis." An additional physician order dated 08/30/13 read, "Vital signs on return from dialysis." A record review of resident #46's comprehensive care plan dated 12/31/13 read, "Potential for Complications related to hemodialysis." Goals and approaches were in place. Physician orders for resident #46 dated 02/19/14 read, "Assess dialysis site for presence of bruit/thrill and notify MD (medical doctor) if absent." A review of resident #46's facility document titled "Dialysis Communication Record" for July and August 2014 revealed that resident #46 received 23 dialysis treatments at the dialysis center in July and August 2014. Resident #46's Medication Administration Record (MAR) for the months of July, August and September 2014 revealed that the above physician orders dated 02/19/14 and 08/30/13 had been transcribed to the MAR for each month. The MAR for the months of July, August and September 2014 for resident #46 revealed no documentation indicating that the 02/19/14 physician order to assess resident #46's dialysis site for the presence of bruit/thrill had been implemented. The review also revealed no documentation indicating that the 08/30/13 physician orders to assess resident #46's dialysis site for S/Sx of infection, bleeding, pain, redness, swelling QHR X6 hours S/P dialysis or vital signs on return from dialysis had been implemented.	F 309	and thrill and vital signs upon their return from dialysis by the licensed nurse (LPN or RN). This will be audited by the DON, ADON, or SDC for four weeks. This review will be to verify documentation of bleeding, pain, redness or edema as well as vital signs, bruit and thrill. Upon completion of the four weeks, each resident receiving dialysis treatments shall have their record reviewed at least monthly for three months. All monitoring reports shall be presented by the DON to the monthly QAPI meeting for evaluation and need to continue monitoring. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	

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F 309	Continued From page 8 A facility document titled "Dialysis Log" that was present in resident #46's MAR was filled out through September 8, 2014. The Dialysis Log included vital signs and assessment of S/Sx of infection, bruit and thrill post status dialysis on Monday, Wednesday and Fridays through September 8, 2014. Further review of the MAR and resident #46's chart revealed no other Dialysis Logs for the months of February 2014 through August 2014. A facility document titled "Vital Signs and Weight Record" for the months of July and August 2014 for resident #46 revealed vital signs documented status post dialysis on 07/02/14 and 07/14/14. Facility documents titled "Nurse's Notes" for July and August 2014 for resident #46 revealed status post dialysis assessment for bruit and thrill on 07/02/14 and read "strong and steady." Further review revealed no further documentation indicating status-post vital signs or dialysis site assessment for bruit and/or thrill was implemented. A Nurse's Notes dated 08/20/14 read, "This nurse was notified by the dialysis center that resident's access shunt was clotted and they had made an appointment for resident to have access port declotted on 08/21/14 and then immediately returning her to be dialyzed after her procedure." Resident #46 returned to the facility on 08/22/14 after her dialysis treatment. On 09/10/14 at 11:10 am, an interview with the Director of Nursing (DON) indicated that it was facility practice to assess and record vital signs upon a resident's return from dialysis and to assess the dialysis site for the presence of a bruit	F 309		

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F 309	Continued From page 9	F 309		

and/or thrill. She also expected the nurse to assess the site for signs and symptoms of infection, bleeding, pain, redness and swelling upon return from dialysis and each shift, but not hourly for the first 6 hours after the resident returned from dialysis. She expected all assessments to be recorded on the MAR, Nurse's Notes or Vital Signs Monitoring Form.

On 09/10/14 at 11:20 am, an interview with Nurse #1 indicated, when a resident came back from the dialysis center the nurse was supposed to assess vital signs, make sure the resident did not have a fever, assess for the thrill at the dialysis site to make sure it was open and not clotted and document assessments on the MAR, nurses notes and/or the Vital Signs Monitoring Form. Nurse #1 revealed that she worked 7:00 am to 3:00 pm and usually did not perform status post dialysis assessments because the resident did not return on her shift.

On 09/10/14 at 1:30 pm, an interview was conducted with the Assistant Director of Nursing (ADON) who indicated that resident #46's Dialysis Log for September 2014 was not supposed to be used by facility staff. She stated, "This Dialysis Log is left over from the previous organization that owned the facility; a nurse must have found it somewhere and pulled it out to use." The ADON indicated that she expected the nurse receiving a status post dialysis resident to assess the dialysis access site for thrill/bruit once upon return from dialysis and assess the site for signs and symptoms of infection once per shift. The ADON indicated that assessments should be documented on the MAR, Vital Signs Monitoring Sheet or Nurse's Notes.

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F 309	Continued From page 10 On 09/10/14 at 3:55 pm, an interview was conducted with resident #46 who indicated that she had returned to the facility around 3:30 pm status post dialysis. Resident #46 stated, "The nurse has not checked my shunt or vital signs yet. The nurses does not always check my vital signs after I get back from dialysis. The nurses do not check my shunt regularly, but I do and if it is not beating then I let the nurse know. It was clogged two weeks ago, the dialysis center found out after I went to dialysis and then I had to go to a hospital to get it unclogged." On 09/10/14 at 5:15 pm, an interview was conducted with Nurse #4, the ADON was present. Nurse #4 indicated that she was new to the facility and not familiar with facility policy, but she knew that when residents came back from dialysis they should have their vital signs checked by a nursing assistant (NA) who should give the results to the nurse for review. Nurse #4 indicated that she would check a resident's dialysis site once per shift for a thrill or bruit and any signs and symptoms of infection. Nurse #4 indicated that she would document the results in the nurse notes or on the MAR. On 9/10/14 at 5:30 pm an observation of Nurse Aide (NA) #9 and #10 revealed that they were taking resident #46's vital signs. On 09/10/14 at 5:45 pm an interview with NA#10 indicated that she had been told by the facility to take scheduled residents vital signs by 6:00 pm when she worked the 3:00 pm to 11:00 pm shift and to report any irregular results to the nurse right away, but otherwise to give results to the nurse after 6:00 pm vitals were completed. NA #10 indicated that NAs are not responsible for	F 309		

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F 309	Continued From page 11 checking resident dialysis access sites. NA #10 indicated that she did not know if dialysis residents' vital signs were supposed to be checked upon return from dialysis or not. On 9/12/14 at 10:50 am, an interview with the facility medical director indicated that he expected vital signs would be included as part of a resident's assessment upon return to the facility, but that checking for a thrill/bruit at the access site would be sufficient once per shift. The medical director indicated that assessing a dialysis access site on a resident for infection, bleeding, pain, redness or swelling is adequate to check once upon a resident's return to the facility and not every hour for 6 hours after a resident returns. He also indicated that he expected the facility to follow physician orders and ESRD guidelines when assessing residents prior to and status post dialysis treatments.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide oral care to 2 of 3 sampled residents (Resident # 56 and Resident # 34) and failed to remove facial hair on 1 of 3 sampled residents (Resident # 56) who was reviewed for activities of	F 312	1. Resident #56 will have her oral hygiene done by the staff member providing her care. Resident #56 will have unwanted facial hair removed by the staff member providing her care.	10/17/14

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F 312	Continued From page 12 daily living. Findings included: 1. Resident # 56 was admitted on 5/6/14 with diagnoses that included quadriplegia. The Admission Minimum Data Set (MDS), dated 5/13/14, indicated Resident # 56 was cognitively. Behaviors, including refusal of care were not identified on the MDS. The resident was coded as requiring extensive or total dependence for all activities of daily living. Functional limitation in range of motion was coded as affecting all extremities. The care plan, initiated 5/23/14, identified an issue with self care. The goal was to be clean, groomed and dressed by staff daily through the next review. The care plan did not indicate the resident refused care. On 9/8/14 at 3:00 PM an observation was made. The resident had visible chin hair. An observation was made on 9/10/14 at 10:10 AM. Resident # 56 received her morning care. At this time, chin hair was present. The resident complained of dizziness, medication was given. Nursing Assistant (NA) # 1 and the treatment nurse stated they would return later to complete morning care. During an interview on 9/10/14 at 11:30 AM, the resident stated she had a friend that shaved her and provided oral care approximately 3 times per week when she visited. The resident stated she would let the staff provide oral care and shave her, but no one had offered.	F 312	2. Residents will be identified by the MDS coordinator on the MDS and care plans as unable to provide their own oral hygiene. The CNA care cards will be updated as needed and the CNA will provide oral care to those persons incapable to perform this oral hygiene. Residents will be identified by documentation on the CNA care card that they wish to have unwanted facial hair removed. The CNA can observe at bedside to assist in prompt removal while providing daily care. 3. The Staff Development Nurse will educate CNAs and Nurses on the need for proper oral hygiene and having unwanted facial hair removed. The purposes of this procedure of proper oral hygiene are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. This education will be completed by 10/17/14 for all licensed nurses and CNAs. This education will also become part of the orientation process for newly hired licensed nurses and CNAs. 4. The DON, ADON, or SDC will monitor residents that require assistance in providing their own oral hygiene daily for two weeks, then weekly for four weeks, and randomly for three months to follow. An audit for female facial hair will be done five times per week for two weeks, one time per week for one month, and one time per month for three months.	

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F 312	Continued From page 13 An interview was held with the DON on 9/10/14 at 4:23 PM. The DON stated residents should receive mouth care every shift and facial hair should be removed as needed or per the resident's preference. Resident # 56 was alert and oriented. The DON stated at times, Resident # 56 refused care. If a resident refused care, the expectation would be for the NA to encourage the resident, attempt care at a different time and if the refusal of care continued, then the NA was taught to report that refusal to the nurse. The nurse was expected to document the refusal in the nurse ' s notes. The DON observed the resident and stated facial hair should have been removed during morning care. An observation was made of Resident # 56 on 9/11/14 at 9:00 AM. The resident stated staff on the 3-11 shift had removed the facial hair. An interview was held with NA # 1 on 9/11/14 at 1:47 PM. Oral care should be offered during a bath and facial hair should be removed if facial hair is noticed. The NA stated when a resident refused care; she was expected to report the refusal to the nurse. NA # 1 stated she had been assigned to care for Resident # 56 on Tuesday and Wednesday. An interview was held with the resident on 9/11/14 at 4:10 PM. She stated NA # 1 provided care this day, but did not offer oral care. The resident stated her friend that comes in 3 times a week, provided oral care for her. 2. Resident # 34 was admitted on 4/27/11 with diagnoses that included seizures and depression.	F 312	Documentation of all audits will be kept in the Plan of Correction binder held in the administrator□s office. All monitoring documentation will be summarized and presented by the DON or ADON to the facility QAPI meeting for evaluation. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	

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F 312	Continued From page 14 The care plan, with an initiation date of 7/21/14, did not identify Resident # 34 refused care. The care plan identified the resident's self care deficit. The goal was set as the resident would participate with care and be clean, groomed and dressed by his choice. Interventions identified for the staff to use included utilizing, task segmentation to help improve participation in care. The annual care plan meeting, held on 7/21/14 indicated the resident was alert and verbal with some decreased cognition noted. The form indicated the resident required some assistance with ADL's. The quarterly Minimum Data Set (MDS), dated 8/15/14, indicated the resident was moderately cognitively impaired. Behaviors and rejection of care were not identified. Limited assistance was required for personal hygiene. During an interview with Resident # 34 on 9/11/14 at 4:21 PM, he stated no one had offered oral care during morning care. An interview was held with Nursing Assistant (NA) # 3 on 9:40 AM on 9/12/14. She stated she worked with the resident yesterday and today and felt she was familiar with his abilities and routine. When given instruction, such as to change his shirt, the NA stated the resident had to be reminded. The NA added Resident # 34 could complete parts of his morning care, but staff had to be with him. She added he was unable to shave independently, but could brush his teeth if a staff member got the toothbrush out of the drawer, put the toothpaste on the brush and gave verbal cues. The NA stated this morning, the	F 312		

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F 312	Continued From page 15 resident rinsed his mouth out before breakfast, but she did not see him brush his teeth. She acknowledged she had not gotten his toothbrush out for him, did not put toothpaste on the brush and did not offer to assist him with brushing his teeth. She offered no explanation for the lack of assistance with Resident # 34's oral care. NA # 4 was interviewed on 9/12/14 at 9:33 AM. She stated she worked with the resident about once a week. The NA stated oral care should offered in the morning when a resident's bath was given. Resident # 34, the NA stated was able to wash parts of his body and could brush his own teeth as long as staff stood with him and reminded him. The NA stated the resident had a "fluctuating memory" and was unable to retain instructions for very long. She stated if a resident refused care, she would attempt again. If the resident continued to refuse, the NA stated she was expected to report the refusal to the nurse.	F 312		
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 staff interviews and record review, the	F 314	1. Resident #6 has been discharged.	10/17/14

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F 314	Continued From page 16 facility failed to provide weekly wound assessments and treatments for pressure ulcers for 1 of 4 residents (Resident # 6) reviewed for pressure ulcers. Findings included: Resident # 6 was readmitted on 7/7/14 with diagnoses that included end stage renal disease, diabetes, peripheral vascular disease, hypotension and an existing vascular wound on his ankle. There was no Minimum Data Set completed after the resident's return to the facility and prior to a 7/20/14 discharge. A care plan, with a problem date of 6/23/14, indicated Resident # 6 was at risk for developing skin breakdown. The goal was set as the resident would have intact skin, free of redness, blisters, or discoloration over a bony prominence through the next review. Interventions to help prevent skin breakdown were identified as a pressure relieving/reduction mattress, incontinence care using a barrier cream and complete weekly skin checks. The Nursing Admission Information sheet, dated 7/7/14, identified a hard scab on the resident's right ankle and a 1 centimeter (cm) pink area on the sacrum which would be treated with barrier cream. The nurse also identified a Stage II pressure ulcer noted to the left hip. The nurse described the wound bed, for the Stage II left hip ulcer, as light pink in color with no drainage or odor. There were no measurements or treatment identified for the Stage II pressure ulcer.	F 314	2. Any resident with a Braden score of less than thirteen (13) is considered potentially at risk. The Braden score is calculated at time of admission by the admitting licensed nurse. Additionally, Braden scores are updated quarterly with MDS assessment. Upon admission a residents primary sites for potential skin breakdown will follow the Signature Health Care Skin Assessment Protocol which includes taking pictures of the residents' potential areas for disruption of their skin integrity and observation by the CNA as they provide bathing of residents. If the CNA should observe any area of redness or irritation, it is their responsibility to alert the nurse. Likewise, if the nurse should find a reddened area or site of irritation, it would be their responsibility to initiate an intervention. New areas identified will be called to the attending physician and he will order a treatment if needed. Those new issues will be presented at the next days CWB meeting by the wound nurse or licensed nurse. It will be followed each morning thereafter during the CWB meeting and the weekly At Risk Meeting. In an acute episode, a photo will not be taken in order to not delay transfer to the hospital. 3. Nursing staff will be trained on the newly implemented Signature Healthcare skin assessment (as defined in item #2 above) and documentation will be re-inserviced on this program by the Staff Development Nurse by 10/17/14. This will identify new skin breakdown on residents	

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F 314	Continued From page 17 The Weekly Skin Integrity Review, dated 7/11/14, indicated the skin had an open area. The location of the open area was not identified or described. Review of the July 2014 Treatment Record indicated an entry for dressing changes to the right ankle. There were no entries, identifying treatments, for the Stage I sacral ulcer or the Stage II left hip ulcer. Review of the July 2014 Pressure Ulcer Records indicated documentation for the ankle wound. There were no Pressure Ulcer Records found for the Stage I sacral ulcer or the Stage II hip ulcer. An interview was held with the Director of Nursing (DON) on 9/11/14 at 9:55 AM. She stated the facility used wound care protocols. The protocol for a Stage I included the use of a barrier cream. The protocol for a Stage II also included protecting the wound with barrier cream The DON added when a resident developed a new wound, the nurse was expected to determine the cause of the wound, remove the cause if possible and place interventions. When a new wound was discovered a treatment was initiated. Other expectations at the time of a wound discovery included documenting the wound's measurements and a description of the wound so progress could be tracked. The DON stated the wound care nurse was responsible for weekly measurements, descriptions and documentation on the appropriate wound care record. The DON was again interviewed on 9/11/14 at 2:07 PM. The DON reviewed the July 2014 pressure ulcer records, the July 2014 Treatment Record and reviewed the physician's telephone	F 314	going to the hospital, returning from the hospital or on an extended LOA (leave of absence). In the event of an acute episode, photographs will not be taken to prevent any delay in the discharge. Weekly skin observations will be done by a licensed nurse and when a CNA identifies a possible skin issue, the CNA will use the Stop and Watch protocol (this is part of the Interact system for nurses observations - education was given to all RNs, LPNs, and CNAs so that everyone can use this tool to help identify residents that have a change in their normal behaviors - less active, not eating, not sleeping, crying, etc.). This education was done by the Staff Development Nurse and will be completed by 10/17/14. Additionally, the Signature Certified Wound Nurse will be contacted for advice and treatment recommendations for any wound that has declined or is not responding well to the current treatment. The Signature Consultant's recommendations will be suggested to the attending MD for an order to be obtained for the resident. The CWB meeting will follow progress of all wounds to include treatment needs and progress of wound healing. All licensed nurses and CNAs will have education completed by 10/17/14 by the Staff Development Educator. This education will become part of the orientation process for all newly hired licensed nurses and CNAs. 4. The DON, ADON, or SDC will audit residents at risk for skin issues and orders for treatment shall be addressed	

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F 314	Continued From page 18 orders. The DON stated without pressure ulcer records, entries on the July 2014 Treatment Record and lack of physician's order for treatment of the Stage I and the Stage II pressure ulcer, she would have to conclude those 2 pressure ulcers received no treatment. An interview was with the wound care nurse on 9/11/14 at 3:36 PM. She stated there were wound care protocols used for the treatment of pressure ulcers; adding that when a protocol was used, she was expected to complete a physician's telephone order for the treatment. The wound care nurse stated the protocol for a Stage I or a Stage II pressure ulcer included determining the cause of the wound and implementation of an intervention to prevent further breakdown. She added the expectation was to evaluate the wound's size and color and document the findings on a pressure ulcer record form weekly. The treatment nurse stated she was aware of the Stage I sacral wound and the Stage II hip wound for Resident # 6, but offered no explanation why the Stage I sacral pressure ulcer or the Stage II left hip pressure ulcer been not been included on the July 2014 treatment sheet.	F 314	immediately and at the weekly At Risk meeting. The DON, ADON, or SDC will observe at risk residents week days of five times per week for two weeks, then weekly for four weeks and then select five (5) at risk residents for three months to follow. All wounds are discussed at the CWB meeting and At Risk meeting weekly. Data will be presented in summary form by the DON or ADON to the facility monthly QAPI meeting. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		10/17/14

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F 315	Continued From page 19 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to secure the indwelling urinary catheter for 1 of 1 sampled resident (Resident # 56) observed with an indwelling urinary catheter. Findings included: Resident # 56 was admitted on 5/6/14 with diagnoses that included hypertension. The Admission Minimum Data Set (MDS), dated 5/13/14, indicated Resident # 56 was cognitively intact. The indwelling urinary catheter was coded on the MDS. The care plan, dated 5/23/14, identified a device used for bladder elimination. In order to obtain the goal of reduced complications staff were instructed to prevent tension on the urinary meatus from the catheter. An observation was made of Resident # 56 receiving morning care on 9/10/14 at 10:10 AM. The resident was observed with a catheter. The catheter was not secured to prevent tugging or accidently being pulled out. At 11:30 on 9/10/14, Resident # 56 was interviewed. The resident stated she once had a band around her leg to secure the catheter, but the band was uncomfortable. The resident stated no other means of securing the catheter	F 315	1. Resident #56 catheter is in place and secured. 2. All residents with catheters are at risk and will be followed at the CWB meeting and observed daily by the floor nurse or CNA that they are secured. Documentation of this observation will be on the Treatment administration record. 3. Each resident admitted with an appropriate diagnosis for the catheter, will be assessed by the floor nurse for the best means for having the tubing secured. The Staff Development Nurse will re-educate both nurses and CNAs on the necessity of securing catheters and the potential consequences of not securing. These consequences would include trauma to the genital/urinary system, redness, edema or bleeding. This education will be completed by 10/17/14. Additionally those residents with catheters will be discussed at the CWB Meeting on weekdays. Issues related to catheter security, site trauma, bleeding, redness, or edema to the area will be brought to the floor nurse immediately. This education will be added to the orientation process for all newly hired licensed nurses and CNAs. 4. Each resident with a catheter will be observed every day by the CNA for the	

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F 315	Continued From page 20 had been attempted. An observation was made of catheter care on 9/10/14 at 12:15 AM. The catheter was not secured. An interview was held with Nurse # 1 on 9/10/14 at 3:55 PM. The nurse stated if securing the catheter was on the care plan, the catheter should be secured. The nurse stated previously she had tried to secure Resident # 56's catheter with a leg band, but that had not worked. She had not reported the inability to secure the resident's catheter to the Director of Nursing (DON). The nurse stated she had not tried to find a larger leg band or any other type of device, such as tape or a system that would secure the indwelling catheter to the top of the leg. An interview was held with the DON on 9/10/14 at 4:23 PM. The DON stated facility policy indicated catheters are to be secured with a strap to prevent trauma during turning and positioning. The DON stated Resident # 56 was supposed to have her catheter secured. The DON made an observation of Resident # 56 and reported the catheter was not secured. The treatment nurse was also interviewed at this time. She stated she was responsible for assuring indwelling catheters were secured. The treatment nurse observed Resident # 56's catheter at this time and reported it had not been secured. Without the catheter secured, the catheter could be dislodged causing infection or trauma. The treatment nurse stated that while she had observed the resident during morning care, she had not noticed the catheter had not been secured. She added she had placed a leg	F 315	security of the catheter and if necessary notify the nurse of the need to secure the tubing. The DON, ADON, or SDC will observe each resident with a catheter five days per week for two weeks, then weekly for four weeks, then once monthly for three months. Observations that occur during this audit will be recorded in the Plan of Correction binder held in the administrator□s office. All data will be summarized and presented to the facility QAPI meeting monthly. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	

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F 315	Continued From page 21 band to secure the catheter. An interview was held with the resident on 9/11/14 at 4:10 PM. The resident had no complaints or concerns with her indwelling urinary catheter being secured.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the medication error rate was 12% as evidenced by 3 errors out of 25 opportunities for errors (Residents #70, #9 and #56). The findings included: The facility policy entitled, "Medication Administration-Injections, Intramuscular" dated 12/2010 read in part, "11. Aspirate before injecting." 1. Resident #70 was admitted to the facility on 6/11/14. Diagnoses included neurogenic bladder and urinary tract infection. On 9/10/14 at 5:25 PM, Nurse #6 was observed administering intramuscular (IM) Rocephin into Resident #70's right upper arm. She inserted the needle fully into the resident's arm and immediately pushed the syringe plunger to administer the medication without aspirating for blood. During an interview on 9/10/14 at 5:27 PM,	F 332	1. Resident #70 had no adverse reactions to the IM injection. Resident #9 has had no adverse reactions or side effects of the medication not being administered with his meal. Resident #56 has had no adverse reaction to the administered eye medication. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The DON, ADON, or SDC will educate nursing staff on the correct nursing process for administering medications, times, and routes of administering medications. Routes of administration include PO (by mouth), Sub Q (sub-cutaneous), IM (intra-muscular), Sublingual (under the tongue), or oral (anything by mouth). This education will be completed by 10/17/14. Nursing staff upon hiring and orientation will receive	10/17/14

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F 332	Continued From page 22 Nurse #6 stated she does not aspirate for blood when giving IM injections. She did not offer any reason for not aspirating. During an interview on 9/11/14 at 1:50 PM, the Director of Nursing (DON) indicated she expected the nurse to aspirate prior to administering IM medication. 2. Resident # 9 was admitted to the facility on 12/18/13. Diagnoses included congestive heart failure and hypertension. Physician orders revealed Resident #9 was to receive three 6.25 milligram tablets of Coreg, a medication to lower heart rate and blood pressure, three times a day with meals. The Medication Administration Record indicated administration times of 8 AM, 12 noon and 5 PM. On 9/10/14 at 4:50 PM, Nurse #4 was observed to administer three tablets of Coreg 6.25 milligrams to Resident #9 in the resident's room. Supper had not been served. On 9/10/14 at 5:40 PM, Resident #9 was observed receiving his supper tray in the dining room. During an interview on 9/10/14 at 5:47 PM, Nurse #4 indicated it was not her practice to give the medication when the resident actually had his meal. She added supper was always served at 5 PM. During an interview on 9/11/14 at 1:49 PM, the Director of Nursing indicated she expected medications ordered to be given with meals to be given with meals.	F 332	this training. The pharmacist will be brought in to educate on medication administration routes and also perform medication observations at least once on each shift. The DON, ADON, SDC, or MDS nurse will do medication pass observations on all shifts to include all nurses who administer medications. 4. The DON, ADON, or SDC will do a minimum of six medication observations across all shifts over the next 14 days. Additional observations will be done at least weekly for four weeks, then monthly for three months. The pharmacist will participate in these observations as part of item #3 above. Results will be recorded in the facility's Plan of Correction binder held in the administrator's office. If any errors are identified, nurses will be re-educated at that time by the Staff development nurse or DON. All observations will be summarized and presented to the facility QAPI meeting by the DON. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The QAPI Committee consists of the administrator, the DON, SDC, MDS Coordinator, Admission Coordinator, Rehabilitation manager, Medical Director, Director of Social Services, and Environmental Services.	

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F 332	Continued From page 23 3. Resident #56 was admitted to the facility on 5/6/14. Diagnoses included glaucoma. September 2014 physician orders included Isopto Tears 0.5%, one drop to the right eye every 4 hours for glaucoma. On 9/11/14 at 9:16 AM, Nurse #1 was observed to administer 1 drop of Isopto Tears 0.5% into each eye. During an interview on 9/11/14 at 1:49 PM, the Director of Nursing indicated she expected medications to be administered as ordered. During an interview on 9/11/14 at 2:03 PM, Nurse #1 reviewed the order and said she should have administered the eye drop into the right eye only.	F 332		
F 333 SS=G	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: Based on interviews with staff and the primary care physician and record review, the facility failed to administer Vimpat (an anti-convulsant medication) and Dilantin (an anti-convulsant medication) per physician's orders for 1 of 5 residents (Resident # 34) reviewed for medication usage. Findings included: Resident # 34 was admitted on 4/27/11 with	F 333	1. Resident #34 had his Vimpat re-ordered on 09/30/14 at 50 milligrams, by mouth, for two times per day. 2. All residents are potentially affected by this alleged deficient practice. Upon receipt of a telephone order, verbal order, or written order the nurse will enter that medication order into the electronic pharmacy record (EZ Mar). Review of the order and review of the data that was	10/17/14

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F 333	Continued From page 24 diagnoses that included seizures. Review of the care plan, dated 7/21/14, indicated Resident # 34 was at risk for seizures. The goals established included reaming free from injury during seizure activity and maintaining therapeutic levels of anti-convulsant medications. Interventions included giving medications as ordered and monitoring for effectiveness and side effects. The quarterly Minimum Data Set (MDS), dated 8/15/14, indicated the resident was moderately cognitively impaired. Seizure disorder was identified as a diagnosis. Review of a May 16, 2014 neurology consult indicated the resident was assessed with "localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy." The neurologist ordered Vimpat 25 milligrams (mgs) twice daily for one week and then a maintenance dose of 50 mg twice a day. There was no stop date included in the order; only a statement that indicated the medication was for maintenance. The neurologist wrote on the consult to stop the Dilantin 200 mg at bedtime on 5/16/14, since the medication was not controlling the resident's seizures and to continue Keppra (an anti-convulsant medication) 1000 mg every 12 hours. A telephone order received as an order from the neurologist, dated 5/16/14 and signed by the resident's primary care physician (PCP), indicated the Vimpat should be given stat (a medical term used to designate the medication should be given immediately) 25 mg twice a day for 1 week and	F 333	input will be covered (accuracy of input into EZ Mar as well as accuracy of order transcription) at CWB meeting the following morning by the DON or ADON. 3. Nurses will be in-serviced on the correct method of entering medication orders into EZ Mar by Pharmerica. All charts were reviewed for potential areas of variance during the electronic record transition and completed by 09/19/14. Night shift licensed nurses will review all charts each night looking for medication orders, correct any errors (initial the physicians orders as reviewed) and provide written documentation of errors for the DON prior to leaving the building at the end of the shift. All education related to EZ Mar was completed by 9/19/14. EZ Mar education has become part of the orientation process for all newly hired nurses. 4. The DON, ADON, or SDC will check all charts for new orders daily and verifying them in the EZ Mar system daily for two weeks then select 5 new orders weekly for four weeks and select 10 new orders a month for three months. All data will be summarized and presented by the DON or ADON to the facility QAPI meeting monthly for review. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director	

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F 333	Continued From page 25 then a maintenance dose of 50 mg twice a day. The physician's order also indicated the Dilantin be decreased to 100 mg every 3 weeks until discontinued and to continue the Keppra at 1750 mg every 12 hours. Review of the May 2014 Medication Administration Record (MAR), indicated the resident received Dilantin 200 mg every other day at bedtime and Dilantin 300 mg every other day at bedtime. The Dilantin 200 mg was last documented as given on May 14th and the Dilantin 300 mg was last documented on the MAR as given on May 15th. Keppra 1750 mg was administered to the resident twice daily as ordered from 5/1/14 through 5/31/14. There was no entry on the MAR that indicated Vimpat was given in May. Review of the June 2014 MAR was reviewed and revealed an entry for Dilantin 100 mg every other day at bedtime for 3 weeks, then start Dilantin 200 mg every other day at bedtime for 3 weeks. The last day for the Dilantin was documented as 6/5/14. Notations on the MAR indicated Vimpat 25 mg was given twice a day starting on 6/6/14 and ended on 6/12/14. A hand written notation indicated Vimpat 50 mg would be started for 30 days. On 6/13/14, the Vimpat 50 mg was given twice daily until the end of the month. Review of the July 2014 MAR revealed an entry that indicated Vimpat 50 mg would be given twice daily for 30 days. Per documentation on the MAR, the resident received the medication twice daily until 7/13/14. A handwritten entry along side the entry wrote "STOP" after the last dose received on the 13th.	F 333	of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	

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F 333	Continued From page 26	F 333		

The August 2014 physician's orders were reviewed. The entry for Vimpat 50 mg had a handwritten note that indicated the medication was discontinued on 6/16/14.

Nurse's notes for 8/14/14 at 7:30 PM nurse's notes indicated Resident # 34 was in the lobby and was observed having a seizure. The nurse documented the seizure lasted 4 minutes. The Nurse Practitioner (NP) and the Responsible Party were notified.

An interview was held with the Director of Nursing (DON) on 9/11/14 at 11:56 AM. The DON stated any consultation forms received, when a resident returned from an appointment, were reviewed by the nurse working on the hall. The DON reviewed the 5/16/14 neurology consultation and the physician's telephone order and stated based on what she had read, the Vimpat for Resident # 34 had no stop date and should have been continued indefinitely to control the resident's seizures. The nurse reviewed all physician's telephone orders and could not find an order to discontinue the Vimpat. The DON added omitting the Vimpat would be considered a significant medication error since the resident had a seizure in August; which was after the Vimpat was discontinued. She added the resident had not returned to the neurologist that ordered the VIMPAT since the medication had been discontinued. The DON identified the nurse that transcribed the order and the nurse that did the first chart check for the July 2014 orders as the same nurse.

Nurse # 2 was interviewed on 9/11/14 at 3:07 PM. The nurse reviewed the telephone order from 5/16/14 and acknowledged she had been the

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F 333	Continued From page 27	F 333		

nurse that transcribed the order. She also acknowledged she had been the nurse to write discontinue on the MAR beside the Vimpat. Nurse # 2 reviewed the 5/16/14 physician's telephone order for Vimpat and stated maintenance meant the resident would continue on the medication. She acknowledged there was no stop date. She stated end of month reconciliation was done by comparing the new MAR to the old MAR and then looking for any new orders. The nurse reviewed the order and then reviewed the MAR and stated she had made a transcription error. She added Vimpat was an anti-convulsant medication and could cause the resident to have seizures. The nurse stated Resident # 34 had a seizure on 8/14/14.

An attempt to contact the prescribing neurologist was unsuccessful. Her office stated she was out of the office and would not be available for phone calls.

An interview was held with the Medical Director on 9/12/14 at 11:20 AM. He stated he was very familiar with Resident # 34. The MD stated he referred Resident # 34 to the neurologist in May because of uncontrolled seizures despite receiving Keppra and Dilantin. The MD added he wanted the neurologist to evaluate the resident to determine if any new medications were available to control the resident's seizures. The 5/16/14 order was read to the MD. He stated, from a physician's viewpoint, maintenance meant the medication would be needed to be taken forever in order to control seizures. Prior to discontinuing the Vimpat, the MD stated he would have expected the nurse to review the order and notify either him or the neurologist; adding he had not been notified. The MD added that stopping an

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F 333	Continued From page 28 anti-convulsant medication without a taper could lower the seizure threshold and/or cause rebound seizures.	F 333		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to properly thaw 2 packages of ground beef which were defrosting at room temperature. The findings included: During a tour of the kitchen on 9/10/14 at 4:40pm two unopened packages of partially thawed ground beef were observed in the bottom of a 2 compartment sink. There were no other items in the sink and no water running into the sink. During an interview with the Dietary Manager (DM) on 9/10/14 at 4:42pm she stated that the ground beef should not be in the sink. She removed the ground beef and placed it into the refrigerator. On 9/11/14 at 8:30am during a tour of the kitchen the Evening Cook was present and stated he was the person who removed the ground beef from the refrigerator and placed it in the sink because	F 371	1. The ground beef cited was only out for a short amount of time and was promptly returned to the refrigerator for proper thawing. The Dietary Manager identified that per code, cold food must be checked every two hours to verify temperature is 41 degrees or below. Since the food was still over half frozen, as well as out for well under the two hour threshold, the product was placed back in the refrigerator. 2. All dietary staff educated on acceptable handling and thawing of foods by the dietary manager by 10/01/14. 3. Dietary manager will re-educate dietary staff on proper thawing of frozen foods. Foods are to be maintained at proper temperatures. Proper temperature control	10/17/14

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F 371	Continued From page 29 he needed the pan the meat was being thawed in for his meal preparation that evening. He stated he forgot to return the ground beef to the refrigerator.	F 371	for cold is less than 41 degrees, for hot is greater than 135 degrees. Quarterly in-services will be done by the dietary consultant. 4. Observation rounds from the dietary manager or designee to be done daily for four weeks, weekly for four weeks, then monthly rounds for three months. Rounds must include meal preparation and serving as well as thawing items. All rounds will be documented and summarized and presented to the facility QAPI meeting monthly for evaluation. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	
F 428 SS=G	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		10/17/14

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F 428	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on staff interview, interviews with the consultant pharmacist and the Medical Director and record review, the facility's consultant pharmacist failed to identify Vimpat (an anti-seizure medication) had not been administered per physician's orders, failed to identify Dilantin (an anti-seizure medication) had not been administered per physician's orders and failed to notify the facility of a medication irregularity involving 1 of 5 residents (Resident # 34) reviewed for medication usage. Findings included: Resident # 34 was admitted on 4/27/11 with diagnoses that included seizures. The quarterly Minimum Data Set (MDS), dated 8/15/14, indicated the resident was moderately cognitively impaired. Seizure disorder was identified as a diagnosis. Review of a May 16, 2014 neurology consult indicated the resident was assessed with "localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy." The neurologist ordered Vimpat 25 milligrams (mgs) twice daily for one week and then a maintenance dose of 50 mg twice a day. There was no stop date included in the order; only a statement that indicated the medication was for maintenance. The neurologist wrote on the consult to stop the	F 428	1. Resident #34 received an order clarification on 9/30/14 to resume Vimpat 50 mg PO BID. The order was received by the DON. The Pharmacist has been notified of the irregularity by DON and the administrator on 09/24/14 during their monthly visit. Monthly audits will occur for three months to follow to insure there are no further areas of concern. The pharmacist supervisor from Pharmerica will be present within seven days of completion of the assigned pharmacist's visit to conduct a follow up audit on a minimum of 10% of current patient volume for three months. 2. Current residents receiving medications have the potential to be affected. A list of residents with a diagnosis of seizure disorder and/or receiving anticonvulsants was compiled on 10/08/14 by the DON. The DON completed a 100% audit of the charts to verify all residents are receiving anticonvulsants as ordered by the physician. A 100% chart audit will be completed on 10/14/14 by the Pharmacist. The audit will include all residents in the facility. 3. The Pharmacist will provide a list of all residents on anticonvulsants to Director of Nursing and/or Assistant Director of Nursing. The Director of Nursing and or	

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F 428	Continued From page 31 Dilantin 200 mg at bedtime on 5/16/14, since the medication was not controlling the resident's seizures and to continue Keppra (an anti-convulsant medication) 1000 mg every 12 hours. A telephone order, received as an order from the neurologist, dated 5/16/14 and signed by the resident's primary care physician (PCP), indicated the Vimpat should be given stat (a medical term used to designate the medication should be given immediately) 25 mg twice a day for 1 week and then a maintenance dose of 50 mg twice a day. The physician's order also indicated the Dilantin be decreased to 100 mg every 3 weeks until discontinued and to continue the Keppra at 1750 mg every 12 hours. Review of the May 2014 Medication Administration Record (MAR), indicated the resident received Dilantin 200 mg every other day at bedtime and Dilantin 300 mg every other day at bedtime. The Dilantin 200 mg was last documented as given on May 14th and the Dilantin 300 mg was last documented on the MAR as given on May 15th. Keppra 1750 mg was administered to the resident twice daily as ordered from 5/1/14 through 5/31/14. There was no indication on the MAR that Vimpat given during the month of May. The 6/17/14 Medication Regimen Review, completed by the consultant pharmacist, noted the Dilantin had been decreased, the Keppra continued and Vimpat 50 mg twice daily added. There was no notation that indicated the pharmacist had identified Resident # 34 had not received the Vimpat or received the Dilantin as the 5/16/14 physician's order indicated. There	F 428	Assistant Director of Nursing will cross reference the Pharmacist reviews with the facilities list of residents receiving anticonvulsants to ensure all residents receiving anticonvulsants are reviewed. The recommendations will then be reviewed with the Physician by Director of Nursing or Assistant Director of Nursing for review of recommendations for levels and frequency if appropriate, monthly x 3 months and quarterly times two quarters for continued compliance/revision to the plan or until compliance is achieved. The Director of Nursing and or Assistant Director of Nursing will audit all residents charts with a diagnosis of seizures and/or receiving anticonvulsant medication to ensure medication is given as ordered 5 days a week x 2 weeks, then once weekly x 2 months or until compliance is achieved. All Licensed Practical Nurse, Registered Nurse and Medication Technicians will be re-educated by the Staff Development Coordinator, regarding medication administration, including the five rights of medication administration and discontinuation of physician orders, re-education will be completed by 10/13/14. 4. The Pharmacist will report to the Administrator and the DON all findings which will be corrected at the time of discovery. The facility recently had a pharmacist assignment change in August of 2014. A transition to this pharmacist	

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F 428	Continued From page 32 was no indication the pharmacist had made the facility aware of the medication irregularities. Review of the June 2014 MAR was reviewed and revealed an entry for Dilantin 100 mg every other day at bedtime for 3 weeks, then start Dilantin 200 mg every other day at bedtime for 3 weeks. The last day for the Dilantin was documented as 6/5/14. Notations on the MAR indicated Vimpat 25 mg was given twice a day starting on 6/6/14 and ended on 6/12/14. A hand written notation indicated Vimpat 50 mg would be started for 30 days. On 6/13/14, the Vimpat 50 mg was given twice daily until the end of the month. Review of the July 2014 MAR revealed an entry that indicated Vimpat 50 mg would be given twice daily for 30 days. Per documentation on the MAR, the resident received the medication twice daily until 7/13/14. A handwritten entry along side the entry wrote "STOP" after the last dose received on the 13th. The 7/15/14 Medication Regimen Review indicated there were no new medications. There was no documentation the pharmacist had noted or reported the discontinuation of the Vimpat on 7/13/14 and there was no indication the pharmacist had noted or reported the Dilantin had not been administered per the physician's order. The August 2014 physician's orders were reviewed. The entry for Vimpat 50 mg had a handwritten note that indicated the medication was discontinued on 6/16/14. Nurse's notes for 8/14/14 at 7:30 PM nurse's notes indicated Resident # 34 was in the lobby and was observed in the middle of having a	F 428	has resulted in better communication and better follow through. Additionally, the pharmacist supervisor from Pharmerica, will be present within seven days of completion of the assigned pharmacist's visit to conduct a follow up audit on a minimum of 10% of current patient volume for three months. The results will be brought to the meeting by the Director of Nursing and will be noted and reviewed in the monthly Quality Assurance Performance Improvement meeting. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	

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F 428	Continued From page 33 seizure. The nurse documented the seizure lasted 4 minutes. The Nurse Practitioner (NP) and the Responsible Party were notified. The pharmacist's 8/29/14 Medication Regimen Review noted the discontinuation of the Dilantin. There was no dated identified. There was no documentation regarding the discontinuation of the Vimpat. A telephone interview with the consultant pharmacist was held on 9/12/14 at 10:00 AM. The pharmacist stated she had worked with the facility for a month and had not been the pharmacist that reviewed the record for Resident # 34 during the months of June and July 2014. She was not familiar with the resident or his seizure diagnosis. She stated that any information she gave would be based on her personal practice and what she did during monthly medication reviews. She added during monthly chart reviews, she reviewed physician's orders received since the last review. The physician's telephone order, dated 5/16/14, for the Vimpat was read to the pharmacist. She stated maintenance meant to continue indefinately. During a medication review, if the medication had been discontinued, she would look for a discontinue order. If there was no discontinue order she would have questioned why the medication had been stopped. The pharmacist stated the question of stopping the medication, without a discontinuation order, should be documented in the monthly medication review notes.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		10/17/14

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F 441	Continued From page 34 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 35 Based on observation, staff interview, and manufacturer specifications, the facility failed to sanitize a glucometer prior to use for 1 of 2 residents (Resident #57), failed to prevent a contaminated glucometer from coming into direct contact with the top of 1 of 2 medication carts (south hall medication cart), and failed to protect a needle, intended to be used for an intramuscular injection for 1 of 1 resident (Resident #70) observed receiving an intramuscular injection, from contamination. The findings included: 1. Manufacturer specifications for disinfecting the glucometer included, "clean the meter surface with one of the following disinfecting wipes:" "(brand name of a germicidal bleach wipe used by the facility)" . On 9/10/14 at 4:40 PM, Nurse #4 was observed to wipe the surface of a glucometer with an alcohol pad in preparation of going into Resident #57's room to check his blood glucose. The nurse explained she had not been taught how the glucometer was cleaned at the facility. She said it was her preference to wipe the glucometer with alcohol before and after use. The nurse then picked up the glucometer and lancing device and started to enter the resident's room. She was asked to stop and verify the facility policy for cleaning the glucometer. On 9/10/14 at 4:42 PM, the Assistant Director of Nursing (ADON) who also assumed the duties of a staff development coordinator approached Nurse #4 and explained nurses were to disinfect the glucometer, between residents, using a bleach wipe located in the bottom drawer on the medication cart. The ADON demonstrated while instructing the nurse to wipe the meter completely and let air dry for 5 minutes. On 9/10/14 at 4:55 PM, Nurse #4 was observed,	F 441	1. Resident #57 will have their glucometer sanitized as recommended by the manufacturer. Cleaning and disinfecting of the meter and lancing device is as follows: 1. Wash hands with soap and water and dry thoroughly. 2. Inspect for blood, debris, dust or lint anywhere on the meter or lancing device. 3. To clean the meter, use a moist lint-free cloth dampened with a mild detergent. Wipe all external areas of meter or lancing device including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port. 4. To disinfect your meter, clean the meter surface with the following disinfecting wipes: Medline Micro Kill Bleach Germicidal Bleach Wipes. 5. Wipe dry or allow to air dry. 6. Wash hands with soap and water and dry thoroughly. There were no signs or symptoms of adverse reaction to this incorrect process of cleaning the glucometer. There were no signs or symptoms of adverse reaction to the IM injection for resident #70. 2. All residents using glucometers are at risk. All residents receiving intramuscular (IM) injections are potentially at risk for this alleged deficient practice. 3. Re-education was given on glucometer sanitizing to include the following instructions for all LPNs, RNs, and Medication Technicians: Cleaning and disinfecting of the meter and lancing device is as follows: 1. Wash hands with soap and water and dry thoroughly. 2.	

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F 441	Continued From page 36 in the presence of the ADON, to perform the blood glucose check with the sanitized glucometer. When finished, the nurse set the glucometer on a surface near the sink while she removed her gloves and washed her hands. Nurse #4 took the glucometer and placed it directly on top of the medication cart. The nurse then used a bleach wipe and sanitized the glucometer. On 9/10/14 at 5:00 PM Nurse #4 was interviewed and indicated she was uncertain of how to handle the glucometer during the period of time immediately after use and prior to disinfection. The ADON explained to Nurse #4 she could place a paper towel on the medication cart, then set the glucometer on the paper towel and sanitize the glucometer. Following the explanation, the ADON used a bleach wipe on the area of the medication cart that had been in direct contact with the glucometer. Nurse #4 washed her hands. During an interview on 9/11/14 at 4:51 PM, the Director of Nursing (DON) stated that she would have expected the nurse to have been taught about using bleach for sanitizing glucometers. 2. On 9/10/14 at 5:13 PM, Nurse # 6 was observed preparing Rocephin (an antibiotic) for intramuscular (IM) injection for Resident #70. . The nurse used a syringe with attached needle to withdraw 2 cubic centimeters (cc) of 1% lidocaine solution. The nurse then injected the lidocaine solution into a vial of Rocephin powder. Nurse #6 mixed the lidocaine and Rocephin until the powder was reconstituted. She then withdrew the solution into the syringe and laid the syringe with exposed needle on a paper towel located on the top of the medication cart. A glucometer was also on the paper towel. A portion of the distal shaft of the needle came in direct contact with the paper towel and the tip of the needle bumped against	F 441	Inspect for blood, debris, dust or lint anywhere on the meter or lancing device. 3. To clean the meter, use a moist lint-free cloth dampened with a mild detergent. Wipe all external areas of meter or lancing device including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port. 4. To disinfect your meter, clean the meter surface with one of the following disinfecting wipes: Dispatch Hospital Cleaner Disinfectant Towels with Bleach, Medline Micro Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes, or Medline Micro Kill Bleach Germicidal Bleach Wipes. 5. Wipe dry or allow to air dry. 6. Wash hands with soap and water and dry thoroughly. Additionally, the IM injection procedure education will be completed by the SDC by 10/14/14 for all licensed nurses. This education has become part of the orientation process for any newly hired licensed staff. 4. The DON, ADON or SDC and will monitor the use of glucometers. This will be done daily for one week, then weekly for four weeks, and monthly for three months. For IM injections, as they occur, the process will be to observe initial injections to insure adherence to Signature Policy and Procedure. All data will be summarized and presented to the QAPI meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as	

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F 441	Continued From page 37 the glucometer. When asked, Nurse #6 indicated she was going to inject the resident without changing needles. The nurse indicated she had been taught not to recap needles, and had not noticed that the needle had touched anything. Nurse #6 then discarded the syringe and needle, and performed the process again but this time did recap the needle prior to laying it on the medication cart.	F 441	they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services and Environmental Services.	