

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2015
NAME OF PROVIDER OR SUPPLIER ZEBULON REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597		
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F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility staff applied a lap buddy restraint to a resident against her will and with no medical diagnosis, after the resident had a fall. (Resident #54).</p> <p>The findings included: Resident #54 was admitted to the facility on 12/18/14 with diagnoses of Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Persistent Mental Disease, Muscle Weakness, Anxiety and Insomnia. The most recent Admission Minimum Data Set (MDS) dated 12/25/14 revealed that the resident had problems with short and long term memory, was coded as having inattention and disorganized thinking, she was feeling or appears down, depressed or hopeless from 2 to 6 days during the look pack period, had a poor appetite or was overeating, she had no behaviors, required extensive assistance with one person physical assistance for transfer, walk in room, walk in corridor, locomotion on and off the unit, dressing, personal hygiene and bathing. Resident #54 required total dependence with one person physical assist for bed mobility, eating and toilet use. There was no impairment with upper and lower extremities for range of motion. She was not steady, only able stability was with staff assistance for moving from seated to standing</p>	F 221	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>Interventions for affected resident: Director of Nursing (DON) immediately removed Lap Buddy restraint from Resident #54.</p> <p>Interventions for residents identified as having the potential to be affected: An audit of the facility resident population was completed; no other resident in the facility currently has a restraint. Re-education was provided to the facility Director of Nursing by the Regional Clinical Director related to properly assessing residents for restraint use and</p>	2/13/15	

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

TITLE

(X6) DATE

Electronically Signed

02/10/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>position, walking with assistive device, turn around and facing the opposite direction while walking, moving on and of the toilet, surface to surface transfer (transfer between bed and chair or wheelchair). Resident #54 used a walker and wheelchair for mobility. She was always incontinent of bowel and bladder.</p> <p>Record review of the Incident Account Report dated 1/7/15 revealed the resident had a fall which listed the recommendations/new interventions as " lap buddy in reclining wheelchair and elevated foot rest 1/8/15 " .</p> <p>Falls care plan updated 1/7/15 revealed: No problem or goals listed documented. Approaches: Invite, encourage, remind escort to activity programs consistent with resident interests to enhance physical strengthening needs. Referral for screen and treatment as needed physical therapy, occupational therapy and mental health.. Provide resident/family teaching to include safety measures to reduce fall risk. 1/7/15 Patient to be evaluated for a lap buddy for posture and position.</p> <p>Record review of the physician order dated 1/8/15 revealed: Resident may use padded lap tray for positioning and safety on wheelchair.</p> <p>Record review of the physician order dated 1/8/15 revealed patient may use padded lap tray for positioning and safety in wheelchair</p> <p>Record review of the physician ' s order dated 1/8/15 revealed: Clarification of physical therapy order: Physical therapy 5 X (times) week for 2</p>	F 221	<p>ensuring a medical diagnosis is reason for use of a restraint.</p> <p>Systematic Change: Licensed Nurses were re-educated by the facility Director of Nursing related to properly assessing residents for restraint use and ensuring a medical diagnosis is reason for use of a restraint use. Newly hired Licensed Nurses will be in-serviced by the facility Staff Development Coordinator, during their orientation period related to properly assessing residents for restraint use and ensuring a medical diagnosis is reason for use of a restraint use.</p> <p>An audit will be completed by the Director of Nursing on any resident with a restraint. Audit will consist of ensuring the resident is properly assessed and a medical diagnosis is the reason for restraint use. The medical diagnosis for use of the restraint should be evident in the medical record. This audit will be completed weekly for twelve (12) weeks.</p> <p>Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report and review the following restraint audits to the Quality Assurance and Performance Improvement Committee: (a) Number of residents in facility with restraints (b) Medical diagnosis for use of the restraint for any resident in the facility with a restraint</p>		

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F 221	<p>Continued From page 2</p> <p>weeks effective 12/29/14. Treatment to indicate wheelchair management therapeutic activities, caregiver education on wheelchair positioning and restorative program due to poor posture, high fall risk for decline in functional status.</p> <p>Record review of the Physical Restraint care plan dated 1/9/15 revealed:</p> <p>Problem: Use of physical restraint related to proper posture. Type: Lap buddy when in wheelchair.</p> <p>Goal: Will remain free of complications related to restraint use included contractures, skin breakdown, altered mental status, isolation or withdrawal.</p> <p>Approaches:</p> <p>Evaluate for restraint use per facility protocol. Evaluate possible benefits of restraint, alternatives to restraint, need for ongoing use and reason for restraint. Discuss with resident/responsible party need for restraint, any concerns or issues regarding restraint use. Check resident and remove for restraint free times per facility protocol, offer opportunities for restraint-free time and physical activity daily. Provide a safe environment, call light or alarm system, personal items within reach. Consult physical therapy and occupational therapy as needed. Observe, document and notify physician as needed regarding effectiveness of restraint, less restrictive device if appropriate, any negative or adverse effects noted, including decline in mood, behavior, ADL performance, cognitive ability or communication, contracture formation, skin</p>	F 221	<p>(c) Pre-physical restraint and reduction assessment for any resident with a restraint</p> <p>The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.</p>		

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F 221	<p>Continued From page 3</p> <p>breakdown, signs/symptoms delirium, falls/accidents, injuries, agitation, weakness. Reassess quarterly or as needed for continued necessity and appropriateness.</p> <p>Interview with the Director of Nursing (DON) on 1/14/15 at 6:00 PM revealed that the lap buddy was an enabler to keep the resident sitting up.</p> <p>Observation on 1/14/15 at 6:00 PM revealed the resident sitting in a high back wheelchair, eating dinner with the lap buddy in place with her feet elevated on the foot rest.</p> <p>Observation on 1/15/15 at 8:05 AM revealed resident sitting in high back, reclined wheelchair with feet elevated on the foot rest.</p> <p>Interview on 01/15/2015 at 8:33 AM with Nurse Aid (NA) #1 revealed that Resident #54 fell very easy. She was very unsteady on her feet. Therapy was working with her. The lap buddy would keep her from falling. Clarification: she was at risk for falls so this was the safest measure they found to protect the resident. NA #1 continued the resident was repositioned every two hours while toileting her. She would ambulate to the bathroom with the rolling walker and the assist of the NA. While the resident was with the restorative aid, she also was toileted every two hours.</p> <p>Interview with the DON on 01/15/2015 at 8:43 AM revealed that the resident was on therapy case load. Therapy had tried different positioning and wheelchairs. They recommended the lap buddy for positioning. Therapy helped make up the care sheets for restorative.</p>	F 221			

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

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F 221	<p>Continued From page 4</p> <p>Interview on 01/15/2015 at 9:03 AM with the Restorative Aid (RA) revealed that she ambulated the resident after breakfast with the rolling walker and gait belt about 100 feet. The RA said she would place the resident back in wheelchair and let her scoot back in the chair and sit there a few minutes to sit straight up on her own. The RA would then tell Resident #54 what to do and she would do it. The leg rests on the wheelchair were attached and secure, her legs were placed on the leg rests so they wouldn ' t fall off. The RA would then put on the lap buddy and Resident #54 would sit in the wheelchair and sleep or watch television. Also, Resident #54 had a safety alarm attached to her. The RA reported that she did not walk with the resident any more that day. The RA continued that she was sure the NAs walked with the resident because they took her to the bathroom.</p> <p>Care Area Assessment dated 1/14/15 revealed: Proceed to care plan: Staff will monitor every shift for effectiveness and for signs of adverse reactions. Changes in mood/behavior will be reported to physician immediately.</p> <p>Observation on 01/15/2015 at 1:15 PM revealed Resident #54 trying to get restraint off so she would be able to get up. The resident was sitting the wheelchair with lap buddy in place, feet elevated. She was trying to get the restraint out from the arm rest.</p> <p>Observation on 01/15/2015 at 2:48 PM revealed Resident #54 speaking to NA #1 telling her to " take it off " referring to the lap buddy on her wheelchair. The resident was reclined in the high back wheelchair with her feet on the elevated foot rest.</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>Interview with NA #1 on 1/15/15 at 2:48 PM revealed that the resident needed the lap buddy for her safety and sitting up in the wheelchair.</p> <p>Observation on 1/16/2015 8:27AM revealed the resident sitting in the hallway in the reclined high back wheelchair with lap buddy in place and her feet elevated on the foot rest while covered with a blanket.</p> <p>Observation on 1/16/15 at 11:15 AM revealed Resident #54 in high back wheelchair with foot rest in place. Lap buddy was not in place. Lap buddy was attached to right side of the wheelchair and hanging down to the side of the wheelchair. Resident appeared asleep in wheelchair covered with a blanket. She was still at the time of the observation. Staff member approached the resident and indicated that she needed to be pulled up further in the chair and that the lap buddy needed to be put into place. She requested assistance from NA #1. NA #1 assisted in pulling resident up in the chair; resident resisted saying, "No, I don't want to get up." Resident slid to original position. Original position appeared to be a semi-recline. The two staff members pulled the resident back up once again; as they put the lap buddy into place, the resident attempted to resist further, stating, "No, take that off. I don't want it." The lap buddy was left in place at that time</p> <p>Interview with the DON on 01/16/2015 at 11:54 AM revealed that the physical therapist evaluated the resident. The medical diagnosis for the lap buddy was muscle weakness, encephalopathy, which affected balance, dementia which caused confusion so the resident did not know what she</p>	F 221			

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F 221	Continued From page 6 was doing. Resident #54 's balance was much better than when she started therapy. She was discharged from therapy on 1/9/15. Sitting up in chair would train her muscles in her upright posture.	F 221			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain clean floors, walls, resident rooms, resident bathrooms and window sills for the residents of two of two halls (Halls 100 and 200). Findings included: a. Observations on 1/13/14 at 8:25 am revealed in room 202 A floor tiles had a brown colored stain. The wall behind the toilet was stained with a brownish red colored substance similar to rust. b. Observation on 01/13/2015 1:34 PM in room 218 revealed a metal heating unit attached to the wall had brown red colored substance similar to rust on the surface. There was a dried white colored splatter on the heating unit. The towel bar in the bathroom was soiled and sticky. c. Observation on 01/13/2015 10:56 AM in the bathroom shared by rooms 106 and 108 revealed an accumulation of a brown substance in the corners of the bathroom floor. d. Observation on 1/14/15 at 10 am in the	F 253	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1.) Interventions for affected resident: No residents were identified as being affected. Specific room issues were addressed immediately or by a deep cleaning schedule for the resident rooms to be completed by 2/13/15. a. The floor tiles in 202A were cleaned and waxed on 2/11/15 The wall behind the toilet were cleaned and scrubbed. The visible brown stains were removed from	2/13/15	

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F 253	Continued From page 7 bathroom shared by rooms 209-211 revealed an accumulation of a reddish brown colored substance in the corners of the floor behind the toilet. Observation on 1/15/15 at 8:20 am in the bathroom shared by rooms 209-211 revealed an accumulation of a reddish brown colored substance in the corners of the floor behind the toilet remained. e. Observation on 1/15/15 at 8:15 am revealed in bathroom # 203 remained with numerous black colored marks on the wall. f. Observations on 01/13/2015 1:41 PM in room 112 an accumulation of dust, dirt, an ant trap covered with dust and a black substance between the wall and wardrobe. The window sill had brown colored stains. Observation on 1/15/15 at 8:30 am revealed in room 112 the accumulation of dust, dirt, an ant trap covered with dust and a black substance between the wall and wardrobe remained. The window sill remained with a brown colored stain. Observation on 1/15/15 at 9:15 am of room 112 with the administrator and housekeeping supervisor revealed the heavy accumulation of dust, dirt, and ant trap covered with dust remained on the floor between the wardrobe and wall. Interview on 1/15/15 at 10:08 am with housekeeper (HK #1) (who was scheduled on duty 1/15/15) and assigned to Unit 100 revealed "I just missed cleaning" the accumulation of dust, dirt and ant trap between the wardrobe and the wall. HK #2 and #3 who worked on the 1/13/15 and 1/14/15 were unavailable to be interviewed. g. Observation on 1/14/15 at 11 am revealed the wall was heavily soiled with black colored stains behind the toilet in the bathroom shared by rooms 210-212. Additionally, the floor tiles were stained. h. Observation on 1/15/15 at 8:10 am in bathroom shared by rooms 210-212 revealed the	F 253	the tile. Floor tiles were replaced where dark stains could not be removed. b. The metal heating unit was removed by maintenance by 2/10/15. The towel bar was replaced by a new grab bar. c. The bathroom shared by 106 and 108 was cleaned immediately by housekeeping. The substance noted in the bathroom floor corners were scrubbed and cleaned. d. The bathroom shared by rooms 209-211 was cleaned immediately by housekeeping. The reddish-brown substance in the corners behind the toilet was scrubbed and cleaned. e. The walls in bathroom #203 were scrubbed and cleaned. f. The accumulation of dust, dirt, and an ant trap covered in black substance were removed immediately from between the wall and the wardrobe. The window sill was scrubbed and cleaned by housekeeping. g. The walls in the bathroom shared by 210 and 212 were scrubbed and cleaned. The floors were also scrubbed and cleaned by housekeeping. h. The walls and floor in the bathroom shared by 210 and 212 were scrubbed and cleaned by housekeeping. i. The edges of the floor in the hallway between room 202 and 204 were cleaned and scraped immediately. The hallways of the 100 and 200 hall were scraped and cleaned immediately especially near room 218, 215, 208, 204 and the exit door on the 200 hall. j. The floor in the rehab gym is scheduled to be cleaned, stripped and waxed by		

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F 253	<p>Continued From page 8</p> <p>walls and the floor were stained,</p> <p>i. Observation on 1/15/15 at 8:22 am revealed the edges of the floor in the hallway near rooms 202-204 had an accumulation of a brown dried substance. Observation on 1/15/15 at 10:40 am revealed the hallways of the 100 unit and 200 unit had an accumulation of a dark brown/black substance in the corners of the entrance to resident rooms especially room 218, 215,208, 204 and near the exit door on unit 200.</p> <p>j. Observation on 1/15/15 at 8:45 am in the rehab room revealed numerous floor tiles that had brownish rd colored stains on the floor tile.</p> <p>Record review and interview on 1/15/15 at 2:15 PM with Housekeeping district manager revealed the contracted housekeeping services group indicated on 10/21/14 that corners and edges of the floors were unsatisfactory and by 10/28/14 all of the floor corners and edges would be scraped and cleaned. There was no documentation that indicated the plan was effective.</p> <p>Interview on 1/15/15 at 2:30 PM the administrator revealed her expectation was for the facility to be clean.</p>	F 253	<p>2/13/15.</p> <p>2) Interventions for residents identified as having potential to be affected: Administrator and Maintenance Supervisor toured the entire building 1/26/15 to include all resident rooms for needed cleaning or repairs. We added new findings to the schedule for cleaning to ensure resident areas were safe and clean. Housekeeping Manager will inspect resident rooms to ensure its quality. Housekeeping staff will follow housekeeping procedures and the deep clean checkoff list to ensure all areas are cleaned according to procedure. Housekeeping staff will be re-educated by the Housekeeping district Manager on proper procedures for adequate cleaning and will provide staff with the cleaning schedule. Staff Signatures were collected to ensure staff acknowledgment.</p> <p>3.) Systemic Change More floor tiles were ordered on 2/12/15 to replace stained floor tiles in the rehab gym and resident rooms that could not be removed with stripping and waxing. The floor tiles will be replaced upon arrival of the tile. Floors in all resident rooms will be inspected for stained tiles during routine stripping and waxing. Stained floor tiles will then be replaced by maintenance. Nursing Home Administrator will conduct facility observation tours 3 times a week for 12 weeks. These facility observations tours will be conducted together with the facility Housekeeping Manager. Facility observations tours will include inspecting</p>		

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F 253	Continued From page 9	F 253	<p>five (5) resident rooms to ensure rooms (including floors, resident bathrooms, space behind the wardrobe, windows and walls) are appropriately cleaned and to identify areas of improvement as needed. The results of the observation tours (audits) will be shared with the facility Quality Assurance Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. District Housekeeping Manager will conduct facility observation tours monthly for three (3) months. These observations tours will be conducted together with the facility Housekeeping Manager. Facility observations tours will include inspecting ten (10) resident rooms to ensure rooms (including floors, resident bathrooms, space behind the wardrobe, windows and walls) are appropriately cleaned and to identify areas of improvement as needed. The results of the observation tours (audits) will be shared with the facility Quality Assurance Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.</p> <p>4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee (QA) will discuss and review the results of the</p>		

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F 253	Continued From page 10	F 253	housekeeping audits monthly QA meetings for at least 3 months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing, and determine the need for further auditing beyond the (3) three months.		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to assess the shunt site for bruit and thrill of 1 of 1 residents in the sample receiving dialysis treatment. (Resident #131)</p> <p>Resident #131 was admitted with cumulative diagnoses which included end stage renal disease that required hemodialysis three times per week.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated 1/5/15 revealed Resident #131 was alert and oriented. Resident #131 was independent for eating and required extensive assistance from staff for completion of all other activities of daily living.</p>	F 309	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: Physician order was obtained for Resident</p>	2/13/15	

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(X4) ID PREFIX TAG F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 309	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Continued From page 11</p> <p>Review of the care plan dated 1/1/15 revealed a potential for complications related to hemodialysis. One of the approaches included monitoring the shunt site by palpating for thrill and auscultating for the bruit daily. The vibration of blood going through your arm is called the thrill. A bruit is something that can be heard with a stethoscope over an artery, which indicated turbulent blood flow.</p> <p>Review of the medical record and Treatment Administration Record (TAR) revealed no documentation that the thrills and bruit were assessed except for the recorded assessments on 1/1/15 in the nurses ' notes.</p> <p>Interview on 1/14/15 at 1:05 PM with Nurse #2 revealed the facility ' s protocol was to check the bruit and thrill every shift. Nurse #2 indicated an order is usually obtained from the physician. The documentation would be on the TAR. Continued interview with Nurse #2 indicated the lack of documentation on the TAR for the assessment of the thrill and bruit was an oversight.</p> <p>Interview on 1/14/15 at 1:21 PM with Nurse #7 revealed the documentation for assessment of the bruit and thrill are documented by exception only and if there is a problem we would document the issues.</p> <p>Interview on 1/14/15 at 2:41 PM with Nurse #1 revealed we document the checking of the bruit and thrill on the MAR. Nurse #1 indicated she documented in the nurses notes on 1/1/15 at 3 PM that there was no issue with the shunt. It was unclear during the interview whether the bruit and thrill had been assessed by this nurse.</p>		<p>#131 to perform daily assessment of dialysis shunt and documentation of thrill and bruit. Physician order was transcribed to Resident #131 treatment administration record (TAR).</p> <p>Interventions for residents identified as having the potential to be affected: Current residents (3) in the facility had Physician orders obtained for daily assessment and documentation of thrill and bruit for dialysis shunt. Physician orders were transcribed to the resident's treatment administration record (TAR). Upon admission, residents will be assessed for dialysis orders. If dialysis is present, MD will be contacted for orders to assess and document thrill and bruit daily.</p> <p>Licensed Nurses were in-serviced by the facility Director of Nursing to document daily assessment of thrill / bruit for residents with a dialysis shunt. Observations completed with licensed nurses to ensure staff to assess bruit/thrill. Newly hired Licensed Nurses will be in-serviced by the facility Staff Development Coordinator during their orientation period, to document the daily assessment of bruit / thrill for residents with a dialysis shunt.</p> <p>Systematic Change: Director of Nursing or Unit Manager will audit two (2) dialysis residents twice weekly for twelve (12) weeks to validate documentation of assessment of bruit and thrill daily with the results presented to the Quality Assurance Performance Improvement Committee. Newly hired</p>		

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F 309	Continued From page 12 Interview on 1/14/15 at 2:50 PM with Nurse #8 revealed he would document on the MAR (Medication Administration Record) the assessment of the thrill and bruit. Interview on 1/14/15 at 3:20 PM with Nurse #3 revealed she would only document in the medical record if there was a problem with the thrill and bruit. Interview on 1/16/15 at 3:30 PM via the phone with Nurse #9 revealed she could not recall whether Resident #131 's bruit and thrill was checked Interview on 1/16/15 at 1:11 PM with the director of nurses (DON) revealed her expectation was the facility nurses should have recorded the assessment of the bruit and thrill on the TAR. The DON indicated on admission physician orders to assess the bruit and thrill would have been obtained and transcribed onto the TAR.	F 309	Licensed Nurses will be in-serviced by the facility Staff Development Coordinator during their orientation period, to document the daily assessment of bruit / thrill for residents with a dialysis shunt. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the Director of Nursing will report the dialysis audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.		
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	F 314		2/13/15	

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F 314	<p>Continued From page 13</p> <p>by: Based on observations, record review, and staff and physician interviews, the facility failed to provide treatment for a pressure ulcer in accordance with the physician ' s order for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #--58).</p> <p>The findings included:</p> <p>Resident #58 was initially admitted to the facility on 2/28/13 with cumulative diagnoses which included hypertension (high blood pressure) and atrial fibrillation (a type of abnormal heart rhythm). The resident's most recent Minimum Data Set (MDS) was an annual assessment dated 12/2/14. The MDS indicated that Resident #58 had cognitively intact skills for daily decision making. She required extensive assistance with most of her activities of daily living (ADLs), with the exception of needing supervision only for locomotion on/off the unit and eating. Resident #58's MDS indicated she had one unstageable, unhealed pressure ulcer with a length of 0.5 centimeters (cm); width of 1.5 cm; and depth of 0 cm.</p> <p>Resident #58's Care Plan dated 11/21/14 (with updates 12/6/14 and 12/15/14) included a problem related to actual alteration in skin integrity with a right heel eschar (the dead tissue that sheds or falls off from healthy skin). The Care Plan interventions included, in part: "Follow MD (Medical Doctor) Orders for skin care and treatments (Utilize Best Practice Guidelines)."</p> <p>A review of the resident's medical record revealed that Resident #58 was followed by the facility's consulting wound doctor. The medical record</p>	F 314	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>1) Interventions for affected resident: Resident #58 right heel wound dressing was immediately changed by Nurse #4. Wound was cleansed as ordered by physician and dressing application was completed as ordered by physician. Director of Nursing observed wound cleansing and dressing application of Resident #58 by Nurse #4. Director of Nursing provided one to one re-education with Nurse #4 on properly following physician orders for appropriately cleaning wounds. Nurse #4 completed return demonstration on proper technique for cleaning and completing wound dressing application.</p> <p>2) Interventions for residents identified as having the potential to be affected: * Licensed Nurses were re-educated by Director of Nursing and/or Unit Manager on properly following physician orders for appropriately cleaning wounds and</p>		

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F 314	<p>Continued From page 14</p> <p>included a Wound Care Specialist Evaluation dated 11/24/14. The focused wound exam of the resident's right heel indicated this wound was a pressure ulcer with duration of greater than (>) 498 days. The wound size was noted as 0.5 cm (length) x 0.5 cm (width) x not measurable (depth). The wound progress was noted as, "No Change." New physician orders for the care and treatment of Resident #58's pressure ulcer were received on 11/25/14 and on 12/4/14.</p> <p>Further review of Resident #58 ' s medical record revealed the facility's Wound Care Specialist continued to follow the resident. A Wound Care Specialist Evaluation dated 1/2/15 revealed the wound size was 3 cm (length) x 2.5 cm (width) x not measurable (depth). The wound progress was noted as, "Deteriorated." Additional notes written within the evaluation revealed the long term wound had been difficult to heal. Chronic lower extremity edema (fluid retention) was identified as having contributed to the problem with wound healing. The physician performed a surgical excisional debridement (the surgical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) of the subcutaneous (under the skin) tissue on this date.</p> <p>A review of Resident #58's medical record also included a Wound Care Specialist Evaluation dated 1/8/15. This evaluation indicated the resident's right heel wound size was 1.5 cm (length) x 1 cm (width) x not measurable (depth). The wound progress was noted as, "Improved" on this date. New physician orders for the care and treatment of the resident's right heel pressure ulcer were received on 1/8/15. The Physician's Order dated 1/8/15 read as follows: " D/C</p>	F 314	<p>completing wound dressing application appropriately as ordered by physician.</p> <p>* Newly hired Licensed Nurses will be educated during their orientation period by the facility Staff Development Coordinator on properly following physician orders for appropriately cleaning wounds and completing wound dressing application appropriately as ordered by physician.</p> <p>3) Systematic Change: * Staff Development Coordinator, Director of Nursing or Unit Manager will observe (audit) for appropriate wound cleansing and dressing application technique to include ensuring wound is cleansed appropriately as per physician order and dressing is applied appropriately per physician order. Wound observation audits will be performed with three (3) Licensed Nurses weekly for twelve (12) weeks. * Wound observation audits will be reviewed with the Quality Assurance and Performance Improvement Committee monthly for a minimum of three (3) months to make recommendations to ensure compliance is sustained ongoing; and to determine the need for further wound observation audits beyond the three (3) months.</p> <p>4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report wound care cleaning and wound dressing application audits to the Quality Assurance and Performance Improvement Committee. The Quality</p>		

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F 314	<p>Continued From page 15</p> <p>(Discontinue) tx (treatment) right heel. Clean right heel wound with NS (normal saline). Pat dry. Apply Santyl (an enzymatic debriding ointment) wound bed cover with Fibracol Plus (a wound dressing that consists of a combination of collagen and alginate; the dressing provides a moist wound environment which is conducive to optimal healing) and cover with occlusive dsq (referring to a dressing that closes the wound and excludes it from the air), change daily." A review of the resident's Treatment Record (TAR) revealed the new orders written on 1/8/15 for pressure ulcer treatment were initiated on that date (1/8/15) and initialed as having been provided once daily through the date of review (1/14/15).</p> <p>On 1/14/15 at 10:47 AM, an observation was made of Nurse #4 as she provided the daily wound treatment to Resident #58's right heel pressure ulcer. The nurse was observed as she removed the wound dressing and measured the pressure ulcer. The wound measured 1.8 cm (length) x 1.2 cm (width) x depth (not measurable). Nurse #4 was observed as she cleansed the outside perimeter (intact skin) of the wound with normal saline. The actual wound itself was not cleansed with the normal saline prior to application of the new dressing. When the Fibracol Plus dressing with Santyl was placed on the wound, the Santyl was observed to come into contact with both the wound itself and the healthy, intact skin surrounding the wound. The wound was then covered with an occlusive dressing.</p> <p>An interview was conducted with Nurse #4 on 1/14/15 at 3:15 PM. Upon inquiry as to why Resident #58's wound bed had not been</p>	F 314	Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.		

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F 314	<p>Continued From page 16</p> <p>cleansed with normal saline prior to applying the new dressing, Nurse #4 indicated that she normally would have cleaned the wound itself but acknowledged that she did not do so this time. She stated, "What I would do is clean the wound bed and clean the edgesso I cleaned the edges around the perimeter of the wound and thought the wound itself looked good and I just didn't want to disturb it." When inquiry was made as to why the Santyl ointment was allowed to be in contact with the healthy skin surrounding the wound bed, the nurse indicated that she intended to get the Santyl on the edges of the wound perimeter and that the Santyl ointment wouldn't disturb the healthy skin if it was not necrotic tissue.</p> <p>An interview was conducted with the Director of Nursing (DON) on 1/14/15 at 4:25 PM. Upon inquiry, the DON indicated her expectation was that if the physician's treatment order said to cleanse a wound with normal saline, she would expect the wound bed itself to be cleansed. The DON declined to comment on the use of Santyl ointment outside of the wound bed without first reviewing the medical record and specific physician orders written.</p> <p>An interview was conducted with the Wound Care Specialist (a Medical Doctor or MD) on 1/15/15 at 9:15 AM. Inquiry was made regarding the physician's expectation for cleansing Resident #58's wound. The physician stated that if an order was written to clean her wound with normal saline, she would expect the wound bed itself (as well as the perimeter of the wound) to be cleansed with the normal saline. An inquiry regarding the use of Santyl outside the perimeter of the wound and on healthy tissue was also</p>	F 314			

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

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F 314	Continued From page 17 made at that time. The physician requested an opportunity to review the resident's record and assess the wound itself prior to addressing use of the Santyl on tissues surrounding the wound bed. A follow-up interview was conducted with the Wound Care Specialist on 1/15/15 at 10:45AM. At that time, the physician indicated that, for the most part, she recommended the Santyl ointment be put on the wound itself. The physician noted that the research suggested it may be okay if Santyl came into contact with the healthy tissue around the wound. However, the physician reported she was concerned about the moisture that the Santyl ointment would promote on the healthy skin around the wound. She stated the treatment order was changed (as of today) to specify that a smaller Fibracol Plus pad (smaller than the wound itself) should be used so that the Santyl ointment would remain in the wound bed only. Upon further inquiry, the physician reiterated that she would have expected the wound bed to be cleansed with normal saline prior to the remaining wound treatment and dressings being applied to the pressure ulcer.	F 314			
F 315 SS=G	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 infections and to restore as much normal bladder function as possible.	F 315		2/13/15	

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F 315	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility failed to act upon a resident exhibiting signs and symptoms of a urinary tract infection for 1 of 1 sampled resident. (Resident #62). The findings included: The resident was admitted to the facility on 10/30/14. Her most recent MDS (Minimum Data Set) dated 11/29/14 indicated that she had memory problems with short and long term memory. She was coded that she required extensive assistance with one person physical assistance for all of her Activities of Daily Living (ADLs) except eating, which she required set up help only with supervision. She had no impairment with range of motion. Resident #64 was always incontinent with bowel and bladder. Resident was coded as having diagnoses of Hypertension, Diabetes Mellitus, Hyperlipidemia, Non-Alzheimer ' s Dementia, Hip Joint Replacement, Abnormality of Gait, Muscle Weakness, Cognitive Communication Deficit, Memory Loss, Dementia without Behavioral Disturbance and Memory Loss. Record review of the Care Area Assessment dated 11/6/14 revealed the Resident #62 was admitted from the community hospital needing skilled nursing and rehabilitation. She was status/post fall with fracture requiring surgical replacement of hip. She currently required extensive assistance with bed mobility, walking, locomotion, dressing, and personal hygiene. She	F 315	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: Resident #62 was transferred to the hospital per physician order. 2) Interventions for residents identified as having the potential to be affected: An audit of physician orders from December 2014 to February 2015 was performed for current facility residents to ensure ordered laboratory test including urinalysis were obtained as ordered by physician. After completed audit, no other resident was found to not have laboratory testing including urinalysis obtained as per physician order. The Director of Nursing performed re-education with Licensed Nurses on obtaining lab specimens and tracking of lab results for proper follow-up. The Director of Nursing performed re-education with Licensed Nurses on		

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F 315	<p>Continued From page 19</p> <p>was totally dependent on staff at this time for toileting needs.</p> <p>Record review of the Care Plan dated 12/1/14 revealed the following:</p> <p>Problem: Resident had an active infection and was being treated in an attempt to prevent the spread. Is symptomatic and/or has a positive test indicating contagious stage in urine, symptoms include abnormal labs and abnormal cultures.</p> <p>Goals: Resident will have no signs or symptoms of active infection related to urinary tract infection (UTI). Resident ' s active infection will be treated and show signs of improving or resolution. Resident will maintain adequate hydration as evidenced by moist mucous membranes, supple skin turgor, stable laboratory values as treated until resolution of infectious process. Resident will not spread infection to others. Completed 12/8/14.</p> <p>Approaches: Standard universal precautions in place. Offer and encourage intake of fluids. Administer medications as ordered. Temperature every shift until antibiotics/anti-infective completed. Monitor for side effects related to antibiotic therapy and report to physician, rash, itching, nausea/vomiting/diarrhea. Post antibiotic therapy laboratory work as ordered and report results to physician. Report to physician worsening signs and symptoms infection or lack of improvement from treatment. Encourage good clean hygiene techniques to avoid cross contamination, especially hand</p>	F 315	<p>obtaining and processing STAT lab specimens after hours including weekend and holiday hours. Process for obtaining and processing STAT laboratory specimens after hours includes collecting laboratory specimen and/or urinalysis and sending the specimen to the local hospital laboratory for processing.</p> <p>The Director of Nursing educated Licensed Nurses on the facility twenty-four (24) hour chart check process. The twenty-four (24) hour chart check process will include checking each resident medical record for new physician orders from the previous day to verify transcription of new orders to the Medication Administration Record (MAR), Treatment Administration Record (TAR) or the Lab Tracking Log as applicable. Newly hired Licensed Nurses will be educated during their orientation period on obtaining and tracking lab results for proper follow-up, obtaining and processing lab specimens after hours including weekend and holiday hours and the facility twenty-four (24) hour chart check process.</p> <p>3) Systematic Change: Night shift Licensed Nurses will perform a twenty-four (24) hour chart check process which will include checking each resident medical record for new physician orders from the previous day to verify transcription of new orders to the Medication Administration Record (MAR), Treatment Administration Record (TAR) or the Lab Tracking Log as applicable . A twenty-four (24) hour report form will be</p>		

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F 315	<p>Continued From page 20</p> <p>washing before meals and after bowel movements.</p> <p>Assess need for dietary modification and consult registered dietician as indicated.</p> <p>12/1/14 Levaquin (an antibiotic) 500 mg (milligram) 1 orally every day for 7 days.</p> <p>Record review of nurse note dated 12/25/14, (7-3 shift). Alert and verbal in early AM (morning) but by 10 AM sleepy and out of it though. VS 98.4, 72, 18, 110/75. Spoke with family member and he said usually when she was like this she had a UTI so will pass it along that needs urine specimen in AM.</p> <p>Record review of nurse notes dated 12/25/14, (3-11 shift). Family reported to nurse that patient is in a beginning phase of possible UTI. Order obtained for UA (urinalysis with culture and sensitivity) C&S. Patient had increased confusion.</p> <p>Record review of the nurse note dated 12/25/14 (3-11 shift). Vital signs, blood pressure 133/72, temperature 98.9, heart rate 76 and respirations were 18. Vital signs stable. Sitting up in wheelchair. Had made inappropriate statements through the day. And agitated. Family requested UA done. Order received. Required assistance from staff of two for all ADLs and treatments. Incontinent of bowel and bladder.</p> <p>Record review of the nurse notes dated 12/25/14 (11-7 shift) Temperature was 102.6 and tylenol given for elevated temperature, rechecked 98.8 orally. Resident resting in bed without complaints offered skin warm to touch. Resident takes medications with ease. Alert and oriented, makes needs known. Continued to monitor.</p>	F 315	<p>utilized during shift change report for communication to oncoming Licensed Nurse of pending lab orders and required follow-up as applicable.</p> <p>A lab tracking log will be utilized during clinical rounds by the Director of Nursing, Unit Manager, Staff Development Coordinator, and Resident Care Specialist to monitor for proper follow-up on lab specimens obtained.</p> <p>Director of Nursing, Unit Manager or Staff Development Coordinator will audit ten (10) resident's medical record weekly for twelve (12) weeks to verify twenty-four (24) hour chart checks are completed and new physician orders are appropriately initiated. Director of Nursing, Unit Manager, Staff Development Coordinator, or Resident Care Specialist will audit the Lab Tracking Log daily (Monday-Friday) in Clinical Rounds for twelve (12) weeks to ensure follow-up of lab specimens ordered by the Physician. The results will be presented to the Quality Assurance and Performance Committee.</p> <p>4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper transcribing and obtaining of lab orders and follow up. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.</p>		

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F 315	Continued From page 21 Record review of a physician order 12/25/14 revealed " UA C&S ". The urinalysis was never collected and sent to the laboratory Record review of the nurse notes dated 12/27/14 (3-11 shift) Vital signs were temperature 101.5, heart rate 80, respirations 20 and blood pressure 123/62. Resident alert and verbal but very weak. Complains of weakness, achiness, and nausea. Resident lungs sounds are clear. Gave tylenol for fever. Checked temperature one half hour later, temperature still at 101. Resident appears to have flu like symptoms. Physician was notified, new order sent to emergency room for flu like symptoms. Family, notified. The Resident Transfer Form dated 12/27/14 revealed the resident was transferred to the community hospital for possible dehydration, flu like symptoms and extreme weakness. Record review of the discharge summary from the hospital dated 1/5/15 revealed that the resident ' s admitting diagnosis was urinary tract infection and the second diagnoses was sepsis. No flu diagnosis. There was an infectious disease consultant and the resident was ordered an antibiotic through a PICC (Peripherally Inserted Central Catheter). Interview on 1/16/2015 at 11:42 AM with the Director of Nursing (DON) regarding the UA results revealed the nurse called the physician because laboratory was closed for Christmas. The physician was notified. The DON continued that the UA was collected on 12/29/14. The resident was discharged on the 27th of	F 315	_____ _____		

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F 315	Continued From page 22 December and the laboratory urine was never collected. No documentation was available at the laboratory or the facility to indicate the urine specimen had been sent out by the facility or been received by laboratory. Interview on 1/16/14 with the Administrator and the Regional Consultant revealed that the expectation was that if the physician ' s order was written stat, and the lab was closed, the resident should have been sent to the hospital for collection of the laboratory specimen. If the physician ' s order wasn't written stat, the expectation would be that they would obtain the laboratory specimen the next day, which was 12/26/14. The urinary specimen wasn't collected on 12/26/14. The resident was discharged to the hospital on 12/27/14.	F 315			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide a protein supplement,	F 325		2/13/15	
			The statements included are not an admission and do not constitute		

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F 325	<p>Continued From page 23</p> <p>ordered by the physician as an intervention to help improve the protein levels for 1 of 1 sampled resident with a low albumin level (Resident #131). Findings include:</p> <p>Resident #131 was admitted with cumulative diagnoses which included end stage renal disease that required hemodialysis three times per week.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated 1/5/15 revealed Resident #131 was alert and oriented. Resident #131 was independent for eating and required extensive assistance from staff for completion of all other activities of daily living. A nutritional approach noted on the MDS was a therapeutic diet.</p> <p>Review of the care plan (initial date unclear) with a target goal date of 4/3/15 revealed a goal for the albumin level to be in an acceptable range. Albumin is a protein that is found in the blood. The therapeutic reference range for an albumin level was 3.5-5.2 grams per deciliters (g/dl).</p> <p>Interview on 1/14/15 at 1:11 pm with the facility 's consultant dietitian revealed with the coordination of the dialysis center the goal range for the Resident #131 ' s albumin level was 4.0 gm/dl.</p> <p>Review of Resident #131 ' s medical record revealed the following albumin levels: 06/19/14 3.9 g/dl 07/24/14 3.1 g/dl 08/21/14 3.6 g/dl 11/20/14 3.5 g/dl</p> <p>Review of the medical nutrition therapy</p>	F 325	<p>agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>1) Interventions for affected resident: Resident #131 was discharged on 1/14/15.</p> <p>2) Interventions for residents identified as having the potential to be affected: Licensed Nurses were re-educated by Director of Nursing on the proper procedure for transcribing new orders to the Medication Administration Record (MAR) and Treatment Administration Record (TAR). The Director of Nursing educated Licensed Nurses on the twenty-four (24) hour chart check process which will include checking physician orders from the previous day to verify transcription of new orders to the Medication Administration Record (MAR) and/or Treatment Administration Record (TAR). Newly hired Licensed Nurses will be educated during their orientation period by the facility Director of Nursing or Staff Development Coordinator on the process of transcribing new orders to the Medication Administration Record (MAR), Treatment Administration Record</p>		

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F 325	<p>Continued From page 24</p> <p>assessment form completed on 1/3/15 by the consultant dietitian revealed a height of 67 inches and a usual weight of 275 lbs. The estimated protein needs were 91 grams. The dietitian recommended a protein supplement.</p> <p>Review of the physician orders revealed on 1/3/15 a telephone order for Resident #133 to receive a protein supplement) 30 milliliters daily for 30 days due to a low albumin level. This telephone order was obtained by Nurse #6. Attempts to interview Nurse #6 during the survey were unsuccessful.</p> <p>Interview on 1/14/15 at 1:21 PM with Nurse #7 revealed the documentation to indicate a protein supplement was given to Resident #131 would be initialed on the Medication Administration Record (MAR).</p> <p>Review of Resident #131 ' s January 2015 MAR revealed no documentation to indicate a protein supplement was transcribed onto the form and administered.</p> <p>Interview on 1/14/15 at 2:41 PM with Nurse #1 (who worked 1/5/15-1/7/15, and 1/9/15-1/12/15) revealed she did not give the ordered protein supplement to Resident #131 because it was not transcribed onto the MAR. Nurse #1 indicated the facility did not have a system for checking new orders.</p> <p>Interview on 1/14/15 at 2:50 PM with Nurse #8 revealed the facility practice was to administer the protein supplement as ordered and document on the MAR.</p> <p>Interview on 1/14/15 at 3:20 pm with Nurse #3</p>	F 325	<p>(TAR)and the twenty-four (24) hour chart check process.</p> <p>All current residents were audited for Supplement use.</p> <p>3) Systematic Change: Night shift Licensed Nurses will perform a twenty-four (24) hour chart check process which will include checking each resident medical record for new physician orders from the previous day to verify transcription of new orders to the Medication Administration Record (MAR) and Treatment Administration Record (TAR). Licensed Nurses will communicate with oncoming Licensed Nurses during shift report any new physician orders obtained during their shift as applicable.</p> <p>The Dietitian will assess patients on admission for nutritional needs and document assessments in the chart. If nutritional supplements are required, the Dietitian will ensure Physician Orders are obtained and acted upon. A monthly audit (for a minimum of three (3) months) will be completed by the Dietician on residents with nutritional supplement orders. The audit will include the Dietician reviewing and comparing the Physician Orders and Medication Administration Record (MAR) of residents on nutritional supplements to ensure resident is receiving nutritional supplements as recommended by Dietician and ordered by Physician. The Dietician or Dietary Manager will review in the Quality Assurance and Performance Improvement Committee Meeting the</p>		

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F 325	<p>Continued From page 25</p> <p>revealed the order for a protein supplement should have been transcribed onto the MAR.</p> <p>Interview on 1/16/15 at 3:30 PM via the phone with Nurse #9 (who worked 1/4/15) revealed she could not recall whether she administered protein supplement as ordered to Resident #133.</p> <p>Interview on 1/16/15 at 1:11 PM with the Director of Nursing (DON) revealed the nurse who obtains new orders should transcribe on to the MAR and then place a copy of the order in her communication box. The DON indicated any new orders would be discussed the next day during clinical rounds, but she did not recall seeing the copy of Resident #133 ' s protein supplement order that was written on 01/03/15. During the interview the DON confirmed the staff failed to administer Resident #133 ' s protein supplement as ordered.</p>	F 325	<p>following: (a) Residents on nutritional supplements (b) Nutritional supplement usage including if resident is receiving supplement as recommended by Dietician and ordered by Physician.</p> <p>The Dietitian or Dietary Manager will review supplement usage and audit results during the monthly QA Meetings for a minimum of three (3) months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.</p> <p>Director of Nursing, Staff Development Coordinator and/or Unit Manager will audit ten (10) resident's medical record to ensure twenty-four (24) hour chart check process is completed and any new physician orders from the previous day are transcribed to the resident Medication Administration Record (MAR) and/or Treatment Administration Record as applicable. Audit will be performed five (5) times per week for twelve (12) weeks.</p> <p>4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report audit findings from the twenty-four (24) hour chart check process to the Quality Assurance and Performance Improvement Committee. The Dietitian or Dietary Manager will review supplement usage during the monthly QA Meetings for at least 3 months. The Quality Assurance and Performance Improvement</p>		

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F 325	Continued From page 26	F 325	Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	2/13/15	
F 356 SS=B	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p>	F 356			

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F 356	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post the census for the required nursing staff information for 4 of 5 days (01/12/15 through 01/15/15). Findings included: Observation on 1/12/15 at 12 noon revealed the posted staffing was located on the glass in front of the nurses' station. Review of the form revealed a line item to be completed for "Patient Census at the Start of Shifts". There was no written entry to indicate the patient census. Observation on 1/13/15 at 9 am revealed the staffing was posted but no written entry of the census. Observation on 1/14/15 at 10 am revealed the staffing form was posted but no written entry for census. Observation on 1/15/15 at 4 pm revealed the staffing was posted but no entry about the patient census. Interview with the director of nurses on 1/15/15 at 4:15 pm revealed Nurse #11 was responsible for completing the form. Nurse #11 was responsible for completing the posted staffing was unable to be interviewed during the survey.	F 356	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: No residents were identified as being affected. Interventions for residents identified as having the potential to be affected: Licensed Nurses were re-educated by the Director of Nursing on accurately documenting and posting facility census and staffing hours. Newly hired Licenses Nurses will be provided education during their orientation period on accurately documenting and posting facility census and staffing hours. Systematic Change: Nightly, Licensed Nurse will thoroughly complete Daily Hours/Census Posting sheet including documenting facility census and staffing hours for the next day. This form will be posted in a visible		

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F 356	Continued From page 28	F 356	area in facility. Daily for a minimum of three (3) months, the Director of Nursing, Unit Coordinator or Administrator will audit to ensure Daily Hours/Census Posting is completed noting the facility census and staffing hours. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the DON will report the staffing hours and census posting audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.		
F 371 SS=E	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 record review, observation and staff interview the facility failed to (1) label, reseal, and	F 371	This plan of correction is the center's credible allegation of compliance.	2/13/15	

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F 371	<p>Continued From page 29</p> <p>date opened food items in storage in 1 of 5 days of the survey. (2) Dispose of outdated foods and beverage in 1 of 5 days of the survey (3) Perform cleaning of equipment in 5 of 5 days of the survey. (4) Perform ongoing cleaning of the kitchen floors in 5 of 5 days of the survey. The facility stored staff food in the refrigerator in 1 of 5 days of the survey. Findings included:</p> <p>The facility has a policy titled " Food Storage Principles " revised 6/12/14 which read in part: Procedure #3 Label each package, box, can, container with the expiration date, date of receipt or when the food item was store after preparation.</p> <p>A. Discard foods that have exceeded their expiration dates. "</p> <p>Observation during the initial tour of the kitchen on 1/12/15 at 9 am revealed:</p> <p>1. A. In the milk refrigerator there was a 4 ounce container of thicken liquids with no date or label. There was an open container of orange juice with a use by date of 1/6/15.</p> <p>B. In the vegetable freezer there was:</p> <p>a. An opened 30 pound container of cut green beans that was not resealed. The exposed green beans were dry in appearance with visible ice crystals.</p> <p>b. There was a pitcher of liquid that was not dated or labeled. Some of the liquid had adhered to the pouring spout of the pitcher that had dried.</p> <p>c. There was an open 30 pound box of broccoli cuts that was not resealed and open to air.</p> <p>d. There was an open 30 pound box of cut carrots that was not resealed and exposed to the air.</p> <p>e. A 30 pound open container of mixed</p>	F 371	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.</p> <p>1.) Interventions for affected resident: No residents were identified as being affected.</p> <p>1. A. The 4-ounce container of thicken liquids with no date or label was discarded of by the Dietary Manager upon finding on 1/12/15. The Dietary Manager on 1/12/15 also discarded of the open container of orange juice with the use by date of 1/6/15.</p> <p>B. a. The Dietary Manager discarded of the opened 30-pound container of cut green beans on 1/12/15.</p> <p>b. The Dietary Manager discarded of the pitcher of liquid with no date or label on 1/12/15.</p> <p>c. The Dietary Manager discarded of the 30-pound box of broccoli cuts that not resealed and open to air on 1/12/15.</p> <p>d. The Dietary Manager discarded of the 30-pound box of cut carrots that was not resealed and exposed to air on 1/12/15.</p> <p>e. The Dietary Manager discarded of the 15-pound container of frozen corn that was opened and not resealed on 1/12/15.</p> <p>B. The Dietary Manager discarded of the cookie dough that was open and exposed to air on 1/12/15.</p>		

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F 371	<p>Continued From page 30</p> <p>vegetables was not resealed and was exposed to air. Ice crystals were noted on the vegetables.</p> <p>f. A 15 pound container of frozen corn was opened, and not resealed. Ice crystals were noted on the corn kernels. There was no date when opened.</p> <p>B. In the Pie freezer there was a box of pre formed cookie dough was open and the dough was exposed to the air. Crystals were noted on the first layer of dough appeared dry.</p> <p>C. Raw vegetable refrigerator A container of a white food item. Interview at the time of the observation with the food service manager (FSM) revealed the container was chicken salad that an employee dietary staff member brought into the facility from home and placed in the refrigerator to keep cold. Interviews during these observations with the FSM revealed staff should date, label and reseal packages when opened.</p> <p>2. The door near the dining room had a broken knob and the ring of the knob was loose with sharp edges exposed.</p> <p>3. The convection oven had a build up of black residue on the oven rack and the inside bottom of the oven. The flat grill had an accumulation of dried residual on the surface. The red colored knobs of the gas stove had an accumulation of a sticky dark brown substance. The vent cover to the return air duct had an accumulation of dust/dirt on the grates. The microwave plate was not in the unit.</p> <p>4. The floor had a build up of dust and grease along the baseboards and corners of the floor.</p>	F 371	<p>C. The Dietary Manager discarded the chicken salad upon finding. The Dietary Manager re-educated Cooks and Dietary Aides on 2/5/15 regarding food storage policies.</p> <p>2. The dining room door knob that was noted to be loose was repaired by the Maintenance Assistance on 1/15/15.</p> <p>3. The convection oven and grill were cleaned by the Dietary Manager and the Maintenance Assistant on 1/14/15. A new convection oven and grill were ordered on 1/14/15. The oven and grill are to be installed by the Maintenance Supervisor and the Maintenance Assistant by 2/13/15. The microwave with the missing plate was replaced by a new microwave purchased by the Administrator on 2/10/15.</p> <p>The vent cover to the return air duct was cleaned by the Maintenance Assistant on 1/15/15.</p> <p>4. The floors, corners, and baseboards were cleaned by the Dietary Staff immediately. The floors, corners, and baseboards were scrubbed and deep cleaned by housekeeping staff on 2/5/15.</p> <p>2) Interventions for residents identified as having potential to be affected: Cooks and Dietary Aides were re-educated on labeling and dating procedures, storage guidelines, cleaning procedures, and the kitchen/dining room cleaning schedules on 2/5/15 by the Dietary Manager. Staff Signatures were collected to ensure staff acknowledgment.</p> <p>3.) Systemic Change</p>		

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F 371	<p>Continued From page 31</p> <p>The floor corners of the entrance to the dried storage area and the entrance into and out of the kitchen had a heavy build-up of a black substance.</p> <p>Observations of the kitchen on 1/14/15 4:40 pm revealed the convection oven had a black residue on the oven rack and the inside bottom of the oven. The floor had a build up of dust and grease along the baseboards and corners of the floor. The floor corners of the entrance to the dried storage area and the entrance into and out of the kitchen had a heavy build-up of a black substance. The knob to the entrance of the kitchen from the dining room side remained broken. The red colored knobs of the gas stove had an accumulation of a sticky dark brown substance. 4 of the 6 burner gas pilot on the stove would not light. The vent cover to the return air duct had an accumulation of dust/dirt on the grates. The facility summoned the maintenance worker who cleaned the stove. Interview during the observation with the FSM indicated that the housekeeping department was responsible for ensuring that the floors were clean in the kitchen.</p> <p>Observation on 1/14/15 at 6 pm revealed a container of cooked chicken was stored in the gas oven. The oven was not on. Interview at the time of the observation with Cook #2 and FSM revealed the container of chicken was left over from the lunch meal. A temperature of the chicken was taken by the FSM with her calibrated thermometer and the chicken measured 80 degrees Fahrenheit.</p> <p>Continued observations of the kitchen on 1/15/15 at 8:40 am revealed the convection oven</p>	F 371	<p>The daily, weekly, and monthly cleaning schedules will be signed by Dietary staff completing the task. Staff is to validate cleaning by signing off on checklist each area cleaned after cleaning has occurred. The Dietary Manager will audit the daily and weekly cleaning check off schedules weekly for 12 weeks to ensure compliance and identify area of improvement as needed. The Dietary Manager or Cook on duty will randomly audit for correct storage, labeling and dating in refrigerators, freezers, storage areas and supply rooms. Audits will be performed five (5) times a week for 4 weeks, then three (3) times a week for 4 weeks, and then weekly for 4weeks to ensure compliance and identify area of improvement as needed. Each audit will cover correct storage, labeling, and dating for all refrigerators, freezers, kitchen storage areas, and the dry food storage room. Housekeeping is scheduled to deep clean the kitchen floors once a month per a schedule created by the Dietary Manager. Administrator and Housekeeping Manager will audit the monthly kitchen floor deep cleaning completed by housekeeping monthly for at least 3 months to identify areas for improvement as necessary. The Nursing Home Administrator will make weekly tours with the Dietary Manager of the kitchen and dining room to monitor for correct labeling and dating, appropriate storage, cleanliness through the daily, weekly, and monthly cleaning schedules for 12 weeks to ensure compliance.</p>		

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F 371	<p>Continued From page 32</p> <p>continued to have a black residue on the oven rack and the inside bottom of the oven remained. The floor remained with a build up of dust and crease along the baseboards and corners of the floor. The floor corners of the entrance to the dried storage area and the entrance into and out of the kitchen remained with a heavy build-up of a black substance. The knob to the entrance of the kitchen from the dining room side remained broken. The red colored knobs of the gas stove remained with the accumulation of a sticky dark brown substance. The vent cover to the return air duct remained with an accumulation of dust/dirt on the grates. At the time of the 2nd observation the FSM indicated the microwave plate was broken and was unsure for how long.</p> <p>Interview on 1/15/15 at 11:23 am with the Cook #2 (responsible for cleaning the flat grill and the 6 burner gas stove top) was conducted. During the interview the cook indicated that although he had cleaned the stove and the flat grill he was not able to remove the black residual. Additionally, he indicated that the cleaning agent used by the facility was not effective.</p> <p>Interview on 1/15/15 at 11:40 am with the consultant dietitian revealed since the change of ownership the food service manager assumed responsibility for the operations in the kitchen which included the cleaning and sanitation.</p> <p>Interview on 1/15/15 at 2:30 PM with the administrator revealed she expected items to be labeled, equipment and kitchen to be clean and in good repair.</p>	F 371	4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the Dietary audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		2/13/15	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 33</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to: 1) Store</p>	F 431	F- 431 The statements included are not an		

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F 431	<p>Continued From page 34</p> <p>medications as specified by the manufacturer and/or auxiliary labeling provided by the pharmacy in 2 of 2 medication carts (100 Hall Cart and 200 Hall Cart); 2) Securely store a prescribed medication in 1 of 2 medication carts (200 Hall Cart) during medication pass administration; 3) Discard an expired medication as specified by the drug manufacturer in 1 of 1 medication store rooms; and 4) Store medications in an a container labeled with the minimum identifying information, including the medication name, strength, and expiration date in 1 of 2 medication carts (100 Hall Cart).</p> <p>The findings included:</p> <p>1a) An observation of the 200 Hall medication cart on 1/16/15 at 11:02 AM revealed one bottle of 2.5% vancomycin ophthalmic (eye) solution labeled for Resident #50 was stored in the cart. An auxiliary label placed on the container by the pharmacy indicated the medication needed to be stored in the refrigerator. A review of Resident #50's medical record revealed a current Physician Order was received on 1/14/15 for vancomycin 2.5% solution given as one drop four times daily; begin 4 days before surgery (with surgery scheduled for 1/22/15). The vancomycin ophthalmic solution was labeled as dispensed from the pharmacy on 1/15/15. There was no order in the resident's medical record to cancel the vancomycin eye drops at either the time of the observation or chart review.</p> <p>An interview was conducted on 1/16/15 at 1:25 PM with Nurse #1. Nurse #1 was assigned to the 200 Hall and 200 Hall medication cart. During the interview, Nurse #1 reported that she was not aware that the labeling on the vancomycin eye</p>	F 431	<p>admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>1) Interventions for affected resident: Resident #50 was not affected as the medication was not used for resident and was discarded and replaced. Resident #132 medication was discarded and replaced. No residents were harmed by the medication left on the cart. Nurse #1 received one to one re-education regarding proper medication storage and not leaving medications on the medication cart unattended. No residents were harmed by the expired medication. Expired medication was returned to pharmacy and re-ordered. No resident were affected by this deficient practice of pills being in the bottom of the medication cart, the medication carts were cleaned and all loose pills were appropriately discarded.</p> <p>2) Interventions for residents identified as having the potential to be affected: Director of Nursing, Unit Manager or Staff development Coordinator performed re-education with Licensed Nurses</p>		

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F 431	<p>Continued From page 35</p> <p>drops for Resident #50 indicated the solution should be stored in the refrigerator. She indicated that the facility would need to call the pharmacy to see what to do with this bottle of eye drops and to find out if a new bottle of vancomycin ophthalmic solution needed to be sent out for Resident #50.</p> <p>An interview was conducted on 1/16/15 at 1:35 PM with the Director of Nursing (DON). During the interview, the storage of vancomycin ophthalmic solution was discussed. The DON indicated that she had taken a telephone order from Resident #50 's physician to cancel the vancomycin ophthalmic solution for the resident after the medication storage observation had been made. The DON reported that at this point in time, Resident #50 "wasn't going to use it (the vancomycin ophthalmic solution) anyway." However, the DON acknowledged that she would have expected a medication labeled as requiring storage in the refrigerator to be stored in the refrigerator, rather than being stored on the medication cart at room temperature.</p> <p>1b) An observation of the 100 Hall medication cart on 1/16/15 at 11:40 AM revealed 1 bottle of FML Forte ophthalmic suspension (a fluorometholone steroid suspension used as an eye drop) was stored laying down on its side in the drawer of the medication cart. The manufacturer's labeling on the box of FML Forte ophthalmic suspension read, in part: "Store in upright position." The ophthalmic suspension was labeled for use by Resident #132 and dispensed by the pharmacy on 9/15/14. A review of Resident #132's Physician Orders revealed there was a current order for the medication to be given as one drop in both eyes daily.</p>	F 431	<p>regarding medication storage, leaving medications unattended on the medication cart and properly discarding medications not in the original package. Newly hired Licensed Nurses will be educated by the Staff Development Coordinator during their orientation period regarding medication storage, not leaving medication on the medication cart unattended and properly discarding medications not in the original package.</p> <p>3) Systematic Change: Director of Nursing, Unit Manager or Staff Development Coordinator will randomly perform medication cart and treatment cart audits to ensure proper medication storage. Audit will be performed twice (2 times) weekly for twelve (12) weeks. Pharmacy Consultant (Quality Assurance Monitor) will perform medication cart and treatment cart audits monthly for a minimum of (3) three months to ensure proper medication storage and proper destruction of medications not in the original package. Results will be presented to the centers monthly Quality Assurance and Performance Improvement Committee.</p> <p>4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the DON will report the results of the audits for proper medication storage to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the</p>		

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F 431	Continued From page 36 An interview was conducted on 1/16/15 at 1:30 PM with Nurse #5. Nurse #5 was assigned to the 100 Hall and 100 Hall medication cart. During the interview, Nurse #5 reviewed the labeling on the FML Forte eye drops and acknowledged that the bottle should be stored in an upright position. An interview was conducted on 1/16/15 at 1:35 PM with the Director of Nursing (DON). During the interview, the storage of the FML Forte ophthalmic suspension was discussed. The DON reported she would expect the eye drops to be stored as indicated by the manufacturer's labeling. 2) An observation of medication administration was conducted on 1/14/15 at 9:16 PM with Nurse #1. Nurse #1 was assigned to the 200 Hall. The nurse was observed as she prepared medications for administration to Resident #34. During this time, Nurse #1 pulled a card containing 2 tablets of 500 milligrams (mg) levofloxacin (a prescription antibiotic) from the medication (med) cart drawer and placed it on top of the med cart. At that time, the nurse indicated that the resident had finished the full course of this antibiotic and no longer needed that medication. At 9:26 AM, the nurse locked the medication cart, left the cart in the hallway (in front of the resident ' s doorway), closed the door, and entered Resident #34's room to obtain his vital sign(s). Nurse #1 was not within view of the medication cart at this time. At 9:30 AM, she returned to the cart to complete the preparation of the resident ' s medications using applesauce and thickener stored on top of the cart. She reentered Resident #34's room at 9:35 AM, again closing the door behind her. The nurse was not	F 431	audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.		

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F 431	<p>Continued From page 37</p> <p>within view of the medication cart at this time. Nurse #1 then pulled the privacy curtain around Resident #34 prior to administering his medication. She exited Resident #34's room and returned to the medication cart at 9:40 AM.</p> <p>An interview was conducted with Nurse #1 on 1/14/15 at 9:41 AM. Upon inquiry, Nurse #1 indicated that she should have put the card containing the levofloxacin in the resident 's drawer of the medication cart for safe storage until the medication pass was completed. Following the interview, Nurse #1 secured the card of levofloxacin in the locked medication cart.</p> <p>During an interview with the Director of Nursing (DON) on 1/16/15 at 1:11 PM, the DON provided a written action plan and indicated that her expectation would be for all medications to be securely stored at all times.</p> <p>3) An observation of the Medication Store Room refrigerator on 1/16/15 at 1:07 PM revealed an opened vial of Tuberculin PPD (purified protein derivative) injectable medication (used for skin test in the diagnosis of tuberculosis) was dated as having been opened on 12/5/14. The manufacturer's labeling on the vial read in part, "Once entered, vial should be discarded after 30 days."</p> <p>During an interview with Nurse #1 on 1/16/15 at 1:25 PM, the nurse indicated the opened vial should have been discarded after being open for 30 days. She stated it needed to be sent back to the pharmacy or discarded at this time.</p> <p>During an interview with the Director of Nursing (DON) on 1/16/15 at 1:35 PM, the DON</p>	F 431			

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F 431	Continued From page 38 addressed the normal procedure for storing opened injectable medications such as Tuberculin PPD. The DON indicated that a vial of Tuberculin PPD injectable medication should have been discarded within 30 days of opening. 4) An observation of the 100 Hall medication cart on 1/16/15 at 11:40 AM revealed 5 loose, unidentified pills were lying on the bottom of one of the medication cart ' s drawers. An interview was conducted on 1/16/15 at 11:45 PM with Nurse #5. Nurse #5 was assigned to the 100 Hall and 100 Hall medication cart. During the interview, Nurse #5 stated the loose pills needed to be discarded. An interview was conducted on 1/16/15 at 1:35 PM with the Director of Nursing (DON). During the interview, the observation of the loose pills lying at the bottom of the 100 Hall medication cart drawer was discussed. The DON indicated her expectation was for the pills to be stored in properly labeled containers and that any loose, unidentified pills would need to be discarded.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441		2/13/15	

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F 441	<p>Continued From page 39 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to disinfect a shared glucometer (glucose meter used to measure a resident's blood sugar level) in accordance with the disinfectant's manufacturer instructions after the glucometer was used for 1 of 2 residents observed (Resident #109) receiving blood glucose monitoring.</p> <p>The findings included:</p>	F 441	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of</p>		

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F 441	Continued From page 40 According to the Center for Disease Control (CDC) guidelines, shared glucometer devices should be cleaned and disinfected between each patient use. The CDC references additional guidance provided by the Food and Drug Administration (FDA) for manufacturers regarding appropriate products and procedures for cleaning and disinfection of blood glucose meters. The disinfection solvent chosen should be effective against human immunodeficiency virus (HIV), Hepatitis C, and Hepatitis B virus. Healthcare personnel are directed to consult the manufacturers of blood glucose meters in use at their facilities to determine what products, meeting the criteria specified by the FDA, are compatible with their meter prior to using any EPA (Environmental Protection Agency)-registered disinfectant for disinfection purposes. Guidelines for the appropriate disinfection of the facility's shared glucometers were obtained from the [brand name] glucometer manufacturer. The manufacturer indicated there were four EPA-registered disinfectant products validated and approved for use with the [brand name] glucometer used at the facility. Information provided by the manufacturer confirmed that the product used at the facility was an approved disinfectant, when used in accordance with the product labeling. During an interview on 1/15/15 at 12:05 PM, Nurse #5 described the facility's protocol for completing blood glucose checks for the residents requiring one. Nurse #5 indicated that her medication cart had two shared glucometers on it. The nurse reported that she would use the first glucometer (Glucometer #1) on her cart to	F 441	correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: No residents were affected by this deficient practice. 2) Interventions for residents identified as having the potential to be affected: All current residents have the potential to be affected. Director of Nursing performed re-education to Licensed Nurses concerning following manufacture recommendations for glucometer cleaning. Licensed Nurses provided return demonstration of proper procedure in disinfecting glucometer after use utilizing manufacture recommendations. 3) Systematic Change: Director of Nursing , Unit Manager or Staff Development Coordinator will randomly observe five (5) Licensed Nurses weekly for twelve (12) weeks to validate proper procedure for disinfecting glucometer per manufacture recommendations after use. Newly hired Licensed Nurses will be educated with return demonstration of glucometer cleaning to validate proper procedure for disinfecting glucometer per manufacture. 4) Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report glucose disinfection observation audits to the Quality		

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F 441	<p>Continued From page 41</p> <p>check the first resident's blood glucose level, disinfect that meter using [brand name] disinfectant wipes, and allow the meter to dry. Nurse #5 stated that while Glucometer #1 was drying, she would use the second glucometer (Glucometer #2) to check the next resident's blood glucose level, and continue to alternate use of the meters as they were disinfected after each use.</p> <p>An observation was made of Nurse #5 as she completed blood glucose checks for residents on 1/15/15 at 12:10 PM. The nurse was observed as she used Glucometer #1 to check Resident #109's blood glucose level. After using Glucometer #1 to complete this blood glucose check, the nurse used a [brand name] disinfectant wipe to clean and disinfect the meter. Immediately after using the wipe, Nurse #5 took a paper towel and wiped off the glucometer. The nurse placed Glucometer #1 (wrapped in the paper towel) on top of medication cart. At 12:15 PM, Nurse #5 took Glucometer #2 from the medication cart and checked Resident #4's blood glucose level. After using Glucometer #2, the nurse used a [brand name] disinfectant wipe to wipe off that meter. Glucometer #2 was then placed on top of the paper towel wrapped around Glucometer #1 on the medication cart.</p> <p>An interview was conducted on 1/15/15 at 12:20 PM with Nurse #5 to discuss the process of glucometer disinfection. Upon inquiry, Nurse #5 acknowledged that she had wiped Glucometer #1 off with a paper towel after using the disinfectant wipe but had not done so with Glucometer #2. The nurse stated that she should have also dried off Glucometer #2 with a paper towel but had forgotten to do so. Upon further questioning,</p>	F 441	Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.		

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

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F 441	<p>Continued From page 42</p> <p>Nurse #5 reported that her understanding was that the glucometers should always be dried off with a paper towel after being wiped with a disinfectant wipe. A review of the manufacturer's product labeling for the [brand name] disinfectant wipes stored on the cart was completed with the nurse. The manufacturer's labeling read, in part: "Thoroughly wet pre-cleaned, hard, non-porous surface with a wipe, keep wet for 2 minutes (5 minutes if fungus is suspected), and allow to air dry. Use as many wipes as needed for the treated surface to remain wet for the entire contact time." At that time, it was requested that the nurse review the disinfection procedure with Director of Nursing (DON) prior to using either of the glucometers again.</p> <p>An interview was conducted on 1/15/15 at 12:25 PM with the DON to discuss the disinfection process for glucometers. Upon inquiry, the DON stated the glucometers were cleaned after each use and allowed to air dry after being wiped with the disinfectant wipes. Observations of the glucometer disinfection were discussed, along with information regarding the product labeling of the disinfectant wipes.</p> <p>A follow-up interview was conducted on 1/15/15 at 2:22 PM with the DON upon her request. At that time, the DON stated there was not a facility policy regarding the disinfection/cleaning of shared glucometers. However, the DON outlined her expectations for the disinfection of shared glucometers. The DON reported that each cart would have two glucometers on it and that a disinfectant wipe would be used to wipe the glucometer after each use. She noted that once wiped with the disinfectant wipe, the glucometer needed to be left to air dry for 2 minutes in</p>	F 441			

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F 441	Continued From page 43 accordance with product labeling. The DON further reported that the second glucometer kept on the cart needed to be used while the first glucometer was in the process of air drying. The DON confirmed that her expectation was for shared glucometers to be disinfected in accordance to the manufacturer labeling on the approved disinfectant wipes. She indicated that staff education was being provided to ensure that shared glucometers were properly disinfected after each use.	F 441			