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E 000	Initial Comments An unannounced recertification survey was conducted 04/29/2019 through 05/02/2019. The facility was found to be in compliance with the requirement CFR 483.73, Emergency Preparedness Event TZMM11.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		6/4/19

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

Electronically Signed | 05/23/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, the facility failed to maintain dignity by failing to knock on resident room doors and announce their presence before entering resident rooms for 6 of 18 residents observed for dignity. The findings included: 1. Resident # 11 was admitted to the facility on 6/1/2014. Her active diagnoses included diabetes mellitus, hypertension, pneumonia, and anemia. Review of the resident's most recent quarterly assessment Minimum Data Set was completed 4/18/2019 and revealed the resident was assessed as moderately impaired. During as observation on 4/30/2019 at 8:11AM, a nursing assistant was observed to enter the resident's room with a meal tray, but failed to knock on the room door before entering. During an interview with the resident on 4/30/2019 at 8:13AM, the resident stated it did not bother her when the staff entered her room without knocking. 2. Resident # 55 was admitted to the facility on 1/6/2011 with diagnoses that included anemia, hypertension, and diabetes mellitus. Review of the resident's most recent quarterly assessment	F 550	F 550 Disclaimer Tower Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Tower Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tower Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding	

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F 550	Continued From page 2 Minimum Data Set was completed 3/1/2019 and revealed the resident was cognitively intact. During an observation completed on 4/30/2019 at 8:15AM, a nursing assistant was observed to enter the resident's room with a meal tray, but failed to knock on the room door before entering. During an interview with the resident on 4/30/2019 at 8:16AM, the resident stated it did not bother him when staff entered his room without knocking. 3. Resident # 100 was admitted to the facility on 6/12/2013 with diagnoses that included hypertension, hyperlipidemia, aphasia, and depression. Review of the resident's most recent most recent quarterly review dated 4/11/2019 revealed the resident is cognitively intact. During an observation completed on 4/30/2019 at 8:32AM revealed a nursing assistant who entered the resident room but did not knock before entering the room. In an interview with Resident # 100 on 4/30/2019 at 8:34AM, the resident stated he did not care if the staff entered his room without knocking or gaining permission to enter. 4. Resident # 38 was admitted to the facility on 3/3/2018 with diagnoses that included hypertension and diabetes mellitus. Review of the resident's most recent quarterly review minimum data set completed on 4/9/2019 revealed the resident was cognitively intact. During an observation completed on 4/30/2019 at 8:19AM revealed a nursing assistant entering the resident's room without knocking or gaining permission to enter. In an interview with the resident on 4/30/2019 at 8:21AM, the resident stated it did not bother him when staff entered his room without knocking or	F 550	On 4/30/19, the surveyor interviewed affected residents and the facility staff spoke to affected residents regarding staff knocking on doors prior to entering the resident room. The affected residents stated, “It did not bother him/her when the staff entered his/her room without knocking”. Another resident stated, “He did not care if the staff entered his room without knocking or gaining permission to enter”. For the affected residents the facility determined On 5/1/19, the nursing assistant (NA) was in-serviced by the staff facilitator on maintaining residents’ dignity and privacy by knocking on doors and announcing presence prior to entering any resident’s room. On 5/1/19, an in-service for facility staff was initiated by the director of nursing (DON) and staff facilitator on Resident Dignity to include knocking on doors and/or announcing presence prior to entering a resident’s room. In service to be completed by 6/4/19. Beginning on 5/21/19, the DON, the staff facilitator, and/or designee will begin auditing utilizing the Resident Care Audit Tool. The purpose of the audit is to ensure staff are providing dignity to residents by knocking on doors and/or announcing presence before entering room. Any areas of concern will be immediately be addressed by the auditor. 10 audits will be completed weekly for eight (8) weeks, then monthly for one (1) month.	

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F 550	Continued From page 3 gaining permission to enter. 5. Resident # 4 was admitted to the facility on 1/31/2018 with diagnoses that included anemia, hypertension, dementia, and depression. Review of the resident's most recent quarterly review minimum data set dated 4/19/2019 noted the resident had severely impaired cognition. During an observation completed on 4/30/2019 at 8:27AM noted a nursing assistant entered the resident's room without knocking or gaining permission to enter the room. In interview with the resident on 4/30/2019 at 8:33AM she stated she did not even notice the staff member had entered her room without first knocking on the door. 6. Resident # 5 was admitted to the facility on 7/4/2018 with diagnoses that included coronary artery disease, hypertension, and diabetes mellitus. Review of the resident's most recent minimum data set which was an annual assessment completed on 4/22/2019, the resident was assessed as cognitively intact. During an observation made on 4/30/2019 at 8:28AM, a nursing assistant was observed to enter the resident's room without knocking or getting permission to enter the room. In an interview with resident # 5 on 4/30/2019 at 8:35AM revealed the resident was not bothered by the staff entering the resident's room without knocking on the door. Staff interview was conducted with the nursing assistant who was observed to enter the resident rooms without knocking was interviewed on 4/30/2019 at 8:45AM. The nursing assistant reported he was aware he should have knocked on the resident room door before entering. He	F 550	The administrator and/or DON will review and present the findings and trends of the Resident Care Audit Tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for three (3) months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

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F 550	Continued From page 4 stated the residents know he is coming so he thought it would be okay just to go in the room. Staff interview was completed on 5/1/2019 at 10:10AM with the nurse who is responsible for training facility nursing staff. She reported the staff is always trained to knock on resident's room doors before entering the room. She reported she conducts a customer service inservice every 6-8 weeks that included issues of dignity and respect and knocking on resident's room doors before entering. The most recent of the customer service inservices was conducted on 3/18/2019 and the nursing assistant who had been observed entering the resident rooms without knocking was listed as an attendee for the inservice. Staff interview with the facility director of nursing was completed on 5/1/2019 at 10:25AM. The director of nursing stated she expected all staff to knock on the residents' doors before they enter the room. She stated her expectation is that all staff knock before entering residents' rooms.	F 550		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set-a tool used for resident assessment) in the areas of Preadmission Screening and Resident Review (PASRR); Active diagnoses, and Medications for 3 of 30 residents (Resident #49, Resident #77, and Resident #82)	F 641	F 641 On 5/1/19 and 5/21/19, the Minimum Data Set (MDS) Nurse modified the MDS assessment for Resident #49 and Resident #82 to reflect accurate coding of a Level II Preadmission Screening and	6/4/19

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F 641	Continued From page 5 reviewed for MDS accuracy. The findings included: 1. Resident #49 was admitted to the facility 12/7/18. A review of the admission MDS dated 12/14/18 revealed Resident #49 was cognitively impaired, displayed delusions, and rejected care 1-3 out of 7 days during the look back period. All Activities of Daily Living (ADLs), except eating, required extensive to total assistance and Resident #49 had 1 lower limb impaired. Active diagnoses included, but were not limited to anemia, arthritis, CVA (cerebrovascular accident), and depression. "No" was coded for the Preadmission Screening and Resident Review (PASRR) portion of Section A titled "Identification Information" of the MDS. A review of the Care Area Assessment dated 12/14/18 revealed focused areas included cognitive loss/dementia, mood stated, behavioral symptoms, and psychotropic drug use. A review of the care plans dated 12/11/18 revealed a care focus titled "Level II Preadmission Screening and Resident Review (PASRR) Recommendations related to" Serious mental illness: anxiety disorder. An interview was conducted on 5/1/19 at 10:52AM with the Social Worker (SW). The SW confirmed Resident #49 came in with Level II PASRR determined. The SW reported the PASRR information was included in the admission jacket, and further stated the facility process was for the handwritten form (titled 'Admission transcript') to be placed on the residents' chart until the printed face sheet was	F 641	Resident Review (PASARR). On 5/2/19, the MDS Nurse modified the MDS assessment for Resident #82 to reflect accurate coding of injections and the accurate coding of antipsychotic medications on a scheduled and “as needed” (PRN) basis. On 5/1/19, the MDS Nurse modified the MDS assessment for Resident #77 to reflect accurate coding of the active diagnoses. On 5/21/19, the director of nursing (DON) and the MDS consultant initiated a 100% audit of all resident MDS assessments to ensure accurate coding of PASRR level II residents, residents receiving injections, residents receiving scheduled and prn antipsychotics, and active diagnoses. The DON and/or the MDS Consultant will immediately address any areas of concern identified during the audit. The audit will be completed by 6/4/19. On 5/21/19, the MDS Coordinator was in-serviced by the MDS Consultant on accurately coding MDS assessments as indicated by the Resident Assessment Instrument (RAI) manual with emphasis that all MDS assessments are coded accurately to include all PASRR Level II residents, all active diagnoses, injections and antipsychotic medication use. The in-service was completed by 5/21/19. Beginning on 5/30/19, 10% of MDS	

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F 641	Continued From page 6 available. The 'Admission Form' for resident #49 included a PASRR number which ended in the letter "F", which indicated he was determined to be a PASRR Level II. An interview was conducted with the MDS Nurse on 5/1/19 at 2:50PM. She stated she was never told about the 'Admission transcript' sheets, which indicated if a new admission was a PASRR Level II resident. She stated the SW was supposed to send out a list of PASRR Level II residents and updated the list as needed. An interview was conducted with the administrator on 5/1/19 at 3:00PM. She stated the admission process related to PASRR included the Admission Coordinator received a PASRR before the resident was admitted to the facility. The admission coordinator then sent out an admission packet and paperwork to all staff members who needed it. PASRR information should be included in the packet. She further stated the MDS nurse should get her information from the packet or verbally. 2. Resident #77 was admitted to the facility 4/6/19. An Admission MDS dated 4/6/19 revealed the resident was cognitively intact and had no behaviors or rejection of care. He was totally dependent on staff for completion of all ADL's and had both upper and both lower limbs impaired. Active diagnoses listed in Section "I" of the MDS included anemia, diabetes mellitus, thyroid disorder, Alzheimer's, depression, cataracts, insomnia, chronic pain, dry eye syndrome, personal history of TIA (Transient Ischemic Attack) and cerebral infarct without residual deficits.	F 641	assessments will be reviewed by the DON and/or designee, utilizing the MDS Assessment Audit Tool to ensure all residents are coded accurately on the MDS assessment. This includes all residents who have been evaluated for Level II PASARR, all residents receiving injections, all residents receiving antipsychotic medications and active diagnoses. The audit will be completed weekly for eight (8) weeks, then monthly for 1 month. The DON and/or the MDS Consultant will immediately address any identified areas of concern. The Director of Nursing will review and initial the MDS Assessment Audit tool weekly for eight (8) weeks, then monthly for one (1) month. The DON will present the findings and trends of the MDS Assessment Audit tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for three (3) months. The QAPI committee will make recommendations regarding the need for continued monitoring.	

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Review of a Physician's progress note dated 4/10/19 revealed a past medical history which included, but was not limited to "history of stroke with left sided weakness." The Physician's narrative read, in part, "Patient states he had a history of stroke with left-sided weakness that occurred in 2013."

An observation and interview were conducted with Resident #77 on 4/29/19 at 9:10AM. He was seated in a high back wheelchair with a splint on his left hand and splints to both lower legs. He stated he was dependent on staff for all care.

An interview was conducted on 5/1/19 at 10:40AM with the MDS Coordinator. She stated she gathered information to complete the active diagnosis section (Section I) of the MDS for new admissions from discharge summaries, physician progress notes, and a chart review. She also stated if a resident was splinted or received any treatments or medications for a condition it should be included in the active diagnosis section. She also stated, "I should have marked CVA (Cerebrovascular Accident) for (Resident #77. I have included it in his 'additional diagnosis' area, but that is not accurate either because he has residual deficits. So Section I and the additional diagnosis sections are inaccurate for him."

An interview was conducted with the DON on 5/1/19 at 10:50AM. She stated she oversaw MDS with the facility Administrator and her expectation was for the MDS to accurate.

An interview was conducted with the Administrator on 5/1/19 at 10:51AM. She stated she and the DON oversaw the MDS Coordinator

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and her expectation for the MDS was for it to be completed accurately and timely.
3. Resident #82 was admitted to the facility on 4/2/19 from a hospital. Her cumulative diagnoses included major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder.

A review of Resident #82 ' s admission Minimum Data Set (MDS) assessment (dated 4/9/19) was completed. Section A of the MDS revealed the resident was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability. Determination of a level II PASRR resident is made by an in-depth evaluation. Results of the evaluation would be used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care.

A review of Resident #82 ' s care plan included, in part, an area of focus initiated on 4/16/19 entitled, "Level II Preadmission Screening and Resident Review (PASRR) Recommendations related to" Serious mental illness: dx (diagnosis): depression."

An interview was conducted with the facility ' s MDS Nurse on 4/30/19 at 2:45 PM. During the interview, the nurse reviewed Resident #82 ' s admission MDS and confirmed she was not coded as a PASRR Level II resident on this assessment. Upon inquiry, the MDS nurse reported she thought Resident #82 was determined to be a PASRR Level II resident after the admission MDS had been completed. The MDS nurse noted a list of PASRR Level II residents (dated 4/17/19) provided by the facility '

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s Social Worker (SW) did include Resident #82.

An interview was conducted on 5/1/19 at 10:52AM with the facility ' s SW. The SW confirmed at the time of Resident #82 ' s admission on 4/2/19, she had been determined to be a Level II PASRR resident. The SW reported the PASRR information was included in the resident ' s admission information. She also stated the facility process was for the handwritten form (titled 'Admission Transcript') to be placed on the residents' chart until the printed face sheet became available. The 'Admission Form' for Resident #82 included a PASRR number which ended in the letter "F", which indicated the resident was determined to be PASRR Level II.

A follow-up interview was conducted on 5/1/19 at 11:55 AM with the MDS Nurse. During the interview, the nurse reported she now understood Resident #82 had been determined to be a PASRR Level II resident at the time of her admission. She noted a correction to the 4/9/19 admission MDS assessment was made to accurately reflect this resident ' s PASRR level.

An interview was conducted on 5/1/19 at 12:15 PM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for the residents ' MDS assessment to be accurate.

4. Resident #82 was admitted to the facility on 4/2/19 from a hospital. Her cumulative diagnoses included major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder.

A review of Resident #82 ' s physician orders and

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Medication Administration Record (MAR) for April 2019 included the following, in part:
--5 milligrams (mg) haloperidol (an antipsychotic medication) to be injected intramuscularly every 6 hours as needed for agitation (initiated on 4/3/19; and reported on the MAR as administered on 4/3/19, 4/4/19, 4/8/19 and 4/9/19).
--1 mg lorazepam (an antianxiety medication) injected intramuscularly now (initiated on 4/4/19 and given one time on 4/4/19).

A review of Resident #82 ' s admission Minimum Data Set (MDS) assessment (dated 4/9/19) was completed. The MDS revealed the resident had intact cognitive skills for daily decision making. Section E of the MDS indicated the resident exhibited behavioral symptoms not directed towards others on 1-3 days during the 7-day look back period. Section N of the MDS assessment entitled, "Medications," indicated the resident received an injection of any type on one day during the last 7 days. Section N also noted Resident #82 received an antipsychotic medication on a routine basis only.

An interview was conducted on 5/2/19 at 10:00 AM with the facility ' s MDS Nurse. Upon request, the MDS nurse reviewed Section N of Resident #82 ' s MDS assessment. The nurse reported the look back period for this 4/9/19 assessment was 4/3/19 through 4/9/19 and inclusive of these dates. The MDS Nurse reported the one injection reported in Section N was from the resident's tuberculin PPD (an injectable medication used as a screening test for tuberculosis) injected on 4/3/19. After reviewing the resident ' s April 2019 MAR, the nurse reported the MDS assessment should have noted the resident received an injection on 4 of 7 days to include 4/3/19, 4/4/19,

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F 641	Continued From page 11 4/8/19 and 4/9/19. The nurse reported she missed reporting the "as needed" (PRN) injections of haloperidol and lorazepam given to Resident #82 when completing Section N. Upon further inquiry, the MDS nurse stated she, "must have just made a mistake in the coding of this." The nurse reported the MDS assessment also should have indicated Resident #82 received both scheduled and PRN antipsychotic medications during the 7-day look back period. An interview was conducted on 5/2/19 at 1:01 PM with the facility ' s Director of Nursing (DON). During the interview, the concerns noted regarding the accuracy of Section N in Resident #82 ' s MDS assessment were discussed. When asked what her expectation was with regards to the coding of medications on the MDS, the DON stated she would expect the MDS to be coded accurately.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide the required assistance with activities of daily living (ADL) including the removal of facial hair and trimming and cleaning of fingernails for 2 of 2 dependent residents reviewed for ADL care (Resident #70 and Resident #49) Findings included:	F 677	F677 On 5/1/19, Resident #79 was provided ADL care to include the removal of facial hair by the assigned nursing assistant (NA). On 5/1/19, Resident #49 was provided nail care by the assigned NA. On 5/21/19, a 100% audit of resident nail care and resident facial hair was initiated	6/4/19

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F 677	Continued From page 12 1. Resident #79 was admitted to the facility 9/7/17. Review of a Quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 4/3/19 revealed Resident #79 was cognitively impaired, had adequate vision and unclear speech, but understood others. She displayed no behaviors or rejection of care and personal hygiene required extensive staff assistance for completion. Bed mobility, transfers and toileting required total assistance and Resident #79 was totally dependent on staff for bathing. Resident #79 had 1 upper and 1 lower limb impaired. Active diagnoses included, but were not limited to CVA (cerebrovascular accident), non-Alzheimer's dementia, hemiplegia/hemiparesis (paralysis of one side of the body), and muscle weakness. Care plans, last updated 4/3/19, were reviewed and revealed care plans appropriate for Resident #79 with measureable goals and interventions, and included a care plan with a stated focus "At risk for further decline in physical functioning d/t (due to) impaired mobility and cognitive impairments. Resident has dx (diagnosis) of seizures, aphasia, dementia, feeding difficulties, muscle weakness, transient ischemic attacks (TIA's), and cerebral infarct." The stated goal read, "Resident will receive physical assistance with ADLs (Activities of Daily Living) routinely and as needed thru (through) next review." Interventions included, but were not limited to "if resident refuses care offer another time to return and assist." An additional care plan, last updated 4/3/19 read, in part, "Chronic/progressive decline in intellectual functioning characterized by; deficit in memory,	F 677	by the director of nursing (DON) and the staff facilitator. The audit is to ensure all residents have been provided nail care per resident preference to include trimming and clean nails and that facial hair has been removed per resident preference. All areas of concern will be immediately addressed by the DON and staff facilitator. The audit will be completed by 6/4/19. On 5/21/19, an in-service was initiated by the DON and the staff facilitator with licensed nurses and nursing assistants in regards to ADL Care – Nail Care and Removal of Facial Hair. In-service will be completed by 6/4/19. Starting on 5/27/19, the activities director will utilize the ADL Monitoring Tool to ensure that nails are clean and trimmed and facial hair is removed per resident preference. The tool will be completed weekly for eight (8) weeks, then monthly for one (1) month. Any areas of identified concern will be immediately addressed by the DON and/or designee. The DON and/or designee will present the results and trends of the ADL Monitoring Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review the ADL Monitoring Tool to make recommendations for further monitoring and/or interventions to maintain regulatory compliance. The administrator and DON will be	

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F 677	Continued From page 13 judgment, decision making and thought process. At risk for unmet needs and/or compromised dignity." The stated goal read, "(Resident #79) will make decision(s) about choice preference TNR (through next review). (Resident #70) will display understanding by appropriately moving eyes/head in response to questions. Interventions included: "allow/encourage resident to make choices. Allow resident sufficient time to verbalize needs. Provide praise for ADL attempts and task accomplishments." A review of the care tracker (a charting method used by nursing assistants to indicate completion of care) for Resident #79 dated 4/29/19 and 4/30/19 revealed personal hygiene and bathing were completed for resident #79 on each day during the 7:00AM-3:00PM shift. An observation of Resident #79 was made on 4/29/19 at 11:05AM. Resident #79 was awake in bed and had facial hair visible under her chin. When Resident #79 was asked if she preferred to have facial hair she indicated "no" by turning her head from left to right and grabbed her chin with her left hand. An observation of Resident #79 was made on 4/29/19 at 12:35PM. Resident #79 was awake in bed and had facial hair visible under her chin. An observation of Resident #79 was made on 4/29/19 at 4:00PM. Resident #79 was awake in bed and had facial hair visible under her chin. An observation of Resident #79 was made on 4/30/19 at 2:00PM. Resident #79 was awake in bed and had facial hair visible under her chin. When Resident #79 was asked if she preferred to	F 677	responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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have facial hair she indicated "no" by turning her head from left to right and grabbed her chin with her left hand.

An interview was conducted on 4/30/19 at 2:15PM with a Nursing Assistant (NA #1). She stated, "(Resident #79) is total care. She is incontinent and can feed herself with her left hand. Her right hand and arm doesn't work. She is able to use her call bell. I do morning care and that includes bathing, cleaning and clipping nails if needed. She brushes her own teeth. We shave her, but she has not been shaved yet. I was going to do her next. I haven't gotten to my morning care yet. She can answer yes or no questions."

An interview was conducted with the Director of Nursing (DON) and Administrator on 4/30/19 at 2:20PM. The DON stated Resident #79 was total care for all ADL's. She also stated, "(Resident #79) can lift or raise her right arm, but she has poor dexterity. She cannot shave herself and women with facial hair should be offered a shave as needed. She can make her needs very known. She's been known to refuse at times like in the dining room or you might offer care but she won't agree until she's ready. So you offer her care after she's done doing whatever she's doing and she'll agree. She may not want to do something the moment you tell her you want to do something so you have to respect her wishes. Shaving or offering a shave is included in personal hygiene."

2. Resident #49 was admitted to the facility 12/7/18. Review of a quarterly MDS dated 2/25/19 revealed Resident #49 had adequate hearing, vision, and clear speech. Resident #49 was moderately cognitively impaired and displayed no behaviors or rejection of care. All

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ADL's, except eating, required extensive assistance and Resident 349 was totally dependent on staff for bathing. Resident #49 had 1 lower limb impairment. Active diagnoses included, but were not limited to, heart failure, diabetes mellitus, CVA, depression, rheumatoid arthritis and hypertension.

Care plans, last updated 2/25/19 revealed appropriate care planning for Resident #49 and included a care plan focused on activities of daily living. The care plan read, in part, "(Resident #49) is extensive to total care with his ADL's d/t (due to) recent BKA (below knee amputation). He can at times refuse care. Activities of daily living. Personal care will be completed with staff support as appropriate to maintain highest practical level of functioning through next review. Bathing: one person to provide some physical assist. Personal Hygiene/Grooming: little or no help/oversight required. Set up utensils/grooming supplies needed for grooming within easy reach."

An additional care plan, last updated 2/25/19 read, in part, "Decline in intellectual functioning characterized by: deficit in memory, judgment, decision making and thought process related to: CVA. At risk for unmet needs and/or compromised dignity short term memory loss." Interventions included "Resident will make decisions about choice or preference. Allow/encourage resident to make choices."

Review of the Care Tracker entries for Resident #49 revealed bathing had not been completed 4/29/19, 4/30/19, or 5/1/19. Personal hygiene had been completed 4/29/19 and 4/30/19.

An observation and interview was completed on

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4/29/19 at 11:15AM with Resident #49. His fingernails extended approximately ¾" (three-fourths of an inch) beyond his fingertips and had a brown substance beneath his thumb nail and index fingers. When asked, Resident #49 stated the facility clipped his nails one time monthly, but that was not enough for his preference.

An additional observation was conducted on 4/30/19 at 9:30AM, 4/30/19 at 2:30PM, and 5/1/19 at 9:00AM. Resident #49 was awake and alert for each observation and had fingernails which extended approximately ¾" beyond his fingertips and had a brown substance beneath his thumb and index finger.

An observation was conducted on 5/1/19 at 11:25AM. Resident #49 held up both hands, smiled, and said, "Look! They just cut my nails. I'm so much happier now. Thank you so much."

An interview was conducted with Nursing Assistant (NA #1) on 5/1/19 at 11:25AM. She stated she had just cut Resident #49's fingernails and would clean under them when she showered him later in the morning. She also stated she had not been assigned to him before today during this week.

An interview was conducted with NA #2 on 5/1/19 at 11:55AM. She stated, "(NA #1) was assigned to him yesterday and today, but I know him (Resident #49). He can help with his ADL's, but doesn't cut his own fingernails. I cut them when I see they need it-when I bathe him or give him showers. He doesn't refuse care, and can verbalize his needs."

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F 677	Continued From page 17 An additional interview was conducted with NA #1 on 5/1/19 at 12:00PM. She stated she was assigned Resident #49 yesterday (4/30/19) and his fingernails were ling, but, "he didn't ask for them to be cut." She also stated shew typically cleaned under fingernails with morning care. An interview was conducted with the DON on 5/1/19 at 12:02PM. She stated, "Fingernails are clipped as needed and during manicure days-which is an activity. Some fingernails are clipped weekly, some more often. Some family's like to do it, in addition to us doing it, and some like us to do it. It's part of ADL's. Fingernails should be cleaned multiple times per day. Some need it more often than others, and some are independent with it. (Resident #49)'s fingernails should be cleaned multiple times per day. They should be clipped as needed."	F 677		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 34 medication opportunities, resulting in a medication error rate of 11.7% for 2 of 5 residents (Resident #28 and Resident #64) observed during medication pass.	F 759	F759 On 5/1/19, Nurse #1 notified Resident #28's physician of a medication error. The physician did not give a new order. There was no change in the resident's condition. On 5/1/19 the staff facilitator in-serviced Nurse #1 on medication administration and monitored Nurse #1 during a medication pass to verify Nurse	6/4/19

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F 759	Continued From page 18 The findings included: 1. Resident #28 was admitted to the facility 1/28/15, with reentry from the hospital on 1/10/19. Her cumulative diagnoses included diabetes and Stage 3 chronic renal failure. On 5/1/19 at 8:23 AM, Nurse #1 was observed as she prepared medications for administration to Resident #28. The medications administered to the resident included 20 milligrams (mg) /200 mg per 5 milliliters (ml) dextromethorphan / guaifenesin liquid given as 5 ml by mouth from a house stock medication bottle. Dextromethorphan / guaifenesin is a combination medication containing a cough suppressant (dextromethorphan) and an expectorant (guaifenesin) used to treat a cough by thinning mucous secretions. A review of the resident's current medication orders included 100 mg/5 ml guaifenesin syrup to be given as 10 ml by mouth every six hours as needed for cough (use house stock). An interview was conducted on 5/1/19 at 10:41 AM was conducted with Nurse #1. During the interview, the nurse reported she had recalled initially giving 6 ml of the liquid medication to Resident #28, so went back to the resident and administered an additional 4 ml of the medication to her after the med pass observation was completed. Upon request, the nurse compared Resident #28 ' s Medication Administration Record (MAR) to the labeling of the stock bottle containing the liquid medication administered to the resident. The nurse confirmed the label of the stock medication given contained dextromethorphan in addition to guaifenesin.	F 759	#1 was able to demonstrate proper medication administration, On 5/1/19, Nurse #2 notified Resident #64's physician of medication errors. The physician did not give a new order. There was no change in the resident's condition. On 5/1/19 the staff facilitator in-serviced Nurse #2 on medication administration and monitored Nurse #2 during a medication pass to verify Nurse #2 was able to demonstrate proper medication administration, On 5/1/19, the staff facilitator initiated a pro-active education for all nurses. The education covered the 10 Rights of Medication Administration. The in-service will be completed by 6/4/19. Beginning on 5/21/19, medication administration will be audited by the unit manager, staff facilitator and/or designee utilizing the Medication Pass Audit Tool. The audit will ensure the medication administration error rate is below five (5) percent. The audit will be completed weekly for eight (8) weeks, and monthly for one (1) month. The unit manager, staff facilitator and/or designee will immediately address all areas of concern. The DON will review and initial the Medication Pass Audit Tool weekly for eight (8) weeks and monthly for one (1) month to ensure all areas of concern have been addressed. The administrator and/or the DON will review and present the findings and trends of the Medication Pass Audit Tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for three (3) months. Any issues, concerns, and/or trends	

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F 759	Continued From page 19 Dextromethorphan was not part of the medication order. Nurse #1 stated the resident ' s physician would be coming in today and she would need to get an order for the combination dextromethorphan / guaifenesin cough medication administered to the resident. An interview was conducted on 5/1/19 at 11:24 AM with the facility ' s Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the DON stated she would expect the residents ' medications to be given correctly. 2. Resident #64 was admitted to the facility on 3/29/19 from a hospital. Her cumulative diagnoses included diabetes, anemia, hyperlipidemia (high levels of fats and/or cholesterol in the blood), and a Stage 2 pressure ulcer. On 5/1/19 at 9:04 AM, Nurse #2 was observed as she prepared medications for administration to Resident #64. The medications administered to the resident included 20 milligrams (mg) atorvastatin (a medication used to treat high cholesterol and lipids in the blood) given as 1 tablet by mouth. A review of the resident's current physician orders included 20 mg atorvastatin to be given as one tablet by mouth every night at bedtime for hyperlipidemia. The atorvastatin was scheduled for administration to Resident #64 at 8:00 PM. An interview was conducted on 5/1/19 at 10:30 AM with Nurse #2. Upon request, the nurse reviewed Resident #64 ' s Medication Administration Record (MAR). After reviewing	F 759	identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

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the MAR, Nurse #2 confirmed atorvastatin was scheduled to be administered to the resident at 8:00 PM. She reported giving the medication at the wrong scheduled time would mean she needed to complete a medication error report.

An interview was conducted on 5/1/19 at 11:24 AM with the facility ' s Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the DON stated she would expect the residents ' medications to be given correctly.

3. Resident #64 was admitted to the facility on 3/29/19 from a hospital. Her cumulative diagnoses included diabetes, anemia, hyperlipidemia (high levels of fats and/or cholesterol in the blood), and a Stage 2 pressure ulcer.

On 5/1/19 at 9:04 AM, Nurse #2 was observed as she prepared medications for administration to Resident #64. The medications pulled for administration to the resident included, in part, one-500 milligram (mg) tablet of Vitamin C obtained from a stock bottle on the medication cart and one-500 mg tablet of metformin (an antidiabetic medication). The nurse placed the medication tablets (including the Vitamin C and metformin tablets) and capsules pulled for the resident into one medication cup and placed applesauce in a second medication cup.

On 5/1/19 at 9:20 AM, Nurse #2 entered Resident #64 ' s room, handed the resident a med cup containing her medications, then placed the med cup containing applesauce and a spoon on the bedside table within the resident ' s reach. The nurse then stepped out of the room and went to

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the medication cart. While Nurse #2 was out of the room, the resident was observed as she placed tablets from the first medication cup into the second med cup containing applesauce and spooned them into her mouth. As the resident was doing so, she dropped a round, white tablet onto the floor. The nurse was still at the med cart at the time the tablet was dropped. Upon returning to the room, the tablet was observed on the floor and pointed out to the nurse. Nurse #2 picked the tablet up from the floor and stated, "I can't give it to her and I don't know what it is." The nurse was observed as she discarded the round, white tablet into the trash bin attached to the med cart.

After the nurse left Resident #64 ' s room, the nurse stated she was going to move on to administer medications for another resident, "because I'm already behind." When asked what she needed to do about the tablet that was dropped on the floor, the nurse stopped and stated she would look to see if she could figure out which tablet was dropped and would give her another tablet to replace it. The nurse was observed as she reviewed the pharmacy dispensed tablets for Resident #64 and reported, "It has to be the metformin," indicating she would need to give the resident another tablet of metformin. At that time, Nurse #2 was asked to stop and an inquiry was made as to who she could ask if she had questions about medication administration. The nurse reported she would go to her supervisor or Director of Nursing (DON). A request was made for the nurse to consult one of these staff members prior to administering another tablet of metformin to the resident.

On 5/1/19 at 9:32 AM, Nurse #2 was

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accompanied as she went to the nursing station and explained the situation to the DON and Staff Development Coordinator (SDC). The SDC accompanied Nurse #2 back to the med cart and instructed the nurse to get the dropped tablet out of the trash with a gloved hand. The nurse retrieved the tablet and noted the manufacturer ' s imprint (an identification code) on it. With assistance from the SDC, Nurse #2 compared this imprint to the resident ' s metformin and determined it was not a match. Upon review of the stock medications given to Resident #64, the dropped tablet was discovered to be a 500 mg Vitamin C tablet. Nurse #2 then administered one-500 mg tablet of Vitamin C tab to the resident as a replacement for the dropped tablet.

A review of the resident's current physician orders included 500 mg Vitamin C to be given as one tablet by mouth twice daily for 90 days for wound healing (scheduled for 8:00 AM and 8:00 PM daily) and, 500 mg metformin to be given as one tablet twice daily with meals for diabetes (scheduled at 8:00 AM and 5:00 PM).

An interview was conducted on 5/1/19 at 11:24 AM with the facility ' s Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the DON stated she would expect the residents ' medications to be given correctly. When asked if she would expect the nurse administering medications to watch a resident actually take the medications, she stated, "Absolutely."

4. Resident #64 was admitted to the facility on 3/29/19 from a hospital. Her cumulative diagnoses included diabetes, anemia,

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F 759	Continued From page 23 hyperlipidemia (high levels of fats and/or cholesterol in the blood), and a Stage 2 pressure ulcer. On 5/1/19 at 9:04 AM, Nurse #2 was observed as she prepared medications for administration to Resident #64. The medications administered to the resident did not include a ferrous sulfate (iron) tablet. A review of the resident's current physician orders included 325 milligrams (mg) ferrous sulfate to be given as one tablet by mouth every morning for anemia (use house stock). The ferrous sulfate was scheduled for administration to Resident #64 at 8:00 AM. An interview was conducted on 5/1/19 at 10:30 AM with Nurse #2. Upon request, the nurse reviewed Resident #64 ' s Medication Administration Record (MAR). After reviewing the MAR, the nurse reported she did not realize ferrous sulfate had not been administered to Resident #64 during her medication pass. Nurse #2 stated she would talk with her supervisor or DON about the missed ferrous sulfate. However, on 5/1/19 at 10:31 AM, the nurse reported she administered a ferrous sulfate tablet to Resident #64 so she would not miss that dose. An interview was conducted on 5/1/19 at 11:24 AM with the facility ' s Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the DON stated she would expect the residents ' medications to be given correctly.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/4/19

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F 761	Continued From page 24 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility: 1) failed to remove expired medications from 2 of 3 medication carts (1-300 Hall and the 400 Hall med carts) observed; 2) failed to date medications when opened in 2 of 3 medication carts (1-300 Hall and the 400 Hall med carts) to allow for the determination of a medication ' s shortened expiration date; and, 3) failed to store medications as specified by the manufacturer in 1 of 3 medication carts (400 Hall med cart) observed.	F 761	F761 On 5/1/19, an audit of all medication carts and medication rooms was completed by the Staff facilitator, and unit manager. The purpose of the audit was to ensure: 1) no expired medications were stored in the medication carts and medication rooms, 2) medications were dated when opened, and 3) medications were stored as specified by the manufacturer and according to policy. The DON, unit	

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F 761	Continued From page 25 The findings included: 1a) Accompanied by Nurse #3, an observation was made on 4/30/19 at 9:44 AM of the 400 Hall medication cart. The observation revealed an opened vial of Lantus insulin labeled for use by Resident #74 was stored on the medication cart. A handwritten notation written on the outside of the medication bottle containing the vial of insulin indicated the Lantus insulin had been opened on 4/18/19. However, a handwritten notation written directly on the insulin vial itself noted the insulin was opened on 3/15/19. A review of the manufacturer ' s product information revealed once punctured (in use), Lantus insulin vials may be stored under refrigeration or at room temperature for up to 28 days. The shortened expiration date for the vial of Lantus insulin opened on 3/15/19 was determined to be 4/12/19. A review of Resident #74's Physician Orders revealed there was a current order for Lantus insulin to be injected subcutaneously as 20 units every morning for uncontrolled diabetes, with a note to discard the vial 28 days after opening. Documentation on Resident #74 ' s April 2019 Medication Administration Record (MAR) indicated the resident received a dose of Lantus insulin 17 times after the insulin ' s calculated expiration date of 4/12/19. A follow-up interview was conducted on 4/30/19 at 1:50 PM with Nurse #3. During the interview, the nurse indicated she looked at the date on the outside bottle the vial was contained within and not the date on the insulin vial itself. She stated the Lantus insulin needed to be discarded	F 761	manager and/or staff facilitator, immediately addressed all areas of concern. On 5/1/19, the staff facilitator initiated a pro-active education for all nurses. The education covered 1. Checking medications before administration for expired dates, 2. Appropriately discarding expired medications per the pharmacy policy, 3. Medications are stored as specified by the manufacturer and per the pharmacy policy, 4. Medications are dated when opened. The in-service will be completed by 6/4/19. Beginning on 5/3/19, medication carts and medication rooms will be audited by the unit manager, staff facilitator and/or designee utilizing the Medication Cart/Expired Medication QA Audit Tool. The audit will ensure there are no expired medications stored on medication carts and/or medication rooms, medications are stored as specified by the manufacturer, medications are dated when opened. The audit will be completed weekly for eight (8) weeks, and monthly for one (1) month. The unit manager, staff facilitator and/or designee will immediately address all areas of concern. The DON will review and initial the Medication Cart/Expired Medication QA Audit Tool weekly for eight (8) weeks and monthly for one (1) month to ensure all areas of concern have been addressed. The administrator and/or the DON will review and present the findings and trends of the Medication Cart/Expired Medication QA Audit Tool to the Quality Assurance and Performance	

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F 761	Continued From page 26 because it was expired. An interview was conducted on 4/30/19 at 3:49 PM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the observations of the medication storage on med carts were discussed. When asked, the DON stated she would expect nursing staff to follow the manufacturer's instructions regarding shortened expiration dates once insulin was put on the cart at room temperature and/or after it was opened. 1b) Accompanied by Nurse #4, an observation was made on 4/30/19 at 10:18 AM of the 300 Hall medication cart serving the low-numbered 300 Hall rooms. The observation revealed an opened bottle of 0.005% latanoprost ophthalmic solution (an eye drop medication used to treat glaucoma) labeled for Resident #101 was stored on the medication cart. A handwritten notation written on the outside of the bottle indicated it was opened on 3/10/19. An auxiliary label placed on the lantanoprost eye drop bottle by the pharmacy read, "Expires 6 weeks after opening." Based on the date opened, the shortened expiration date of the latanoprost eye drops was 4/21/19. A review of the manufacturer ' s storage instructions for latanoprost ophthalmic solution indicated once opened, the container may be stored at room temperature up to 25o C (77o F) for 6 weeks. A review of Resident #101's Physician Orders revealed there was a current order for 0.005% latanoprost solution to be administered as one drop in each eye every night at bedtime. A notation written with the medication order read,	F 761	Improvement (QAPI) committee monthly for three (3) months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

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"Discard 6 weeks after opened."

Documentation on Resident #101 ' s April 2019 Medication Administration Record (MAR) indicated the resident was administered latanoprost eye drops 9 times after the calculated expiration date of 4/21/19.

A follow-up interview was conducted on 4/30/19 at 1:20 PM with Nurse #4. During the interview, the nurse indicated that based on the date the bottle was opened, the latanoprost eye drops would have been expired.

An interview was conducted on 4/30/19 at 3:49 PM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the observations of the medication storage on the med carts were discussed. When asked, the DON stated she would expect nursing staff to follow the manufacturer's instructions regarding shortened expiration dates of medications.

1c) Accompanied by Nurse #4, an observation was made on 4/30/19 at 10:18 AM of the 300 Hall medication cart serving the low-numbered 300 Hall rooms. The observation revealed an opened vial of Novolog insulin labeled for use by Resident #91 was stored on the medication cart. A handwritten notation written on the insulin vial noted the Novolog insulin was opened on 3/30/19. A review of the manufacturer ' s product information revealed once punctured (in use), Novolog insulin vials may be stored under refrigeration or at room temperature for up to 28 days. The shortened expiration date for the vial of Novolog insulin opened on 3/30/19 was determined to be 4/27/19.

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A review of Resident #91's Physician Orders revealed there was a current order for Novolog insulin to be injected subcutaneously twice daily as sliding scale insulin, with a note to discard the vial 28 days after opening.

Documentation on Resident #91 ' s April 2019 Medication Administration Record (MAR) indicated the resident did not receive a dose of Novolog after the insulin ' s calculated expiration date of 4/27/19.

A follow-up interview was conducted on 4/30/19 at 1:20 PM with Nurse #4. During the interview, the nurse indicated based on the date the vial was opened, the Novolog insulin would have been expired.

An interview was conducted on 4/30/19 at 3:49 PM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the observations of the medication storage on the med carts were discussed. When asked, the DON stated she would expect nursing staff to follow the manufacturer's instructions regarding shortened expiration dates once insulin was put on the cart at room temperature and/or it was opened.

2a) Accompanied by Nurse #3, an observation was made on 4/30/19 at 9:44 AM of the 400 Hall medication cart. The observation revealed a box of 0.63 milligrams (mg) / 3 milliliters (ml) levalbuterol inhalation solution (an inhaled medication used in the treatment of asthma or chronic obstructive pulmonary disease) dispensed from the pharmacy on 3/5/19 for Resident #65 was stored on the med cart. The

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box contained 2 vials of solution partially placed inside of one opened, undated foil pouch. Nurse #3 confirmed the observed storage of the levalbuterol inhalation solution vials.

A review of the manufacturer ' s storage instructions for levalbuterol inhalation solution indicated vials should be used within 2 weeks after opening the protective pouch.

A review of Resident #65 ' s Physician Orders revealed there was a current order for 0.63 mg/3 ml levalbuterol to be used as one premixed unit via nebulizer every 4 hours as needed for shortness of breath. A notation attached to the order read, "Discard 2 weeks in pouch after foiled (foil) is opened or 1 week out of pouch."

Documentation on Resident #65 ' s April 2019 Medication Administration Record (MAR) indicated no doses of levalbuterol were administered to the resident during the month of April.

A follow-up interview was conducted on 4/30/19 at 1:50 PM with Nurse #3. During the interview, the nurse reported the undated levalbuterol vials needed to be discarded.

An interview was conducted on 4/30/19 at 3:49 PM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the observations of the medication storage on the med carts were discussed. When asked, the DON stated she would expect nursing staff to date the foil pouch of nebulizer solutions and to follow the manufacturer ' s instructions to determine the shortened expiration date of opened pouches. The DON added, "When in

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doubt, pitch it."

2b) Accompanied by Nurse #4, an observation was made on 4/30/19 at 10:18 AM of the 300 Hall medication cart serving the low-numbered 300 Hall rooms. The observation revealed a box of 0.5 milligrams (mg) / 2 milliliters (ml) budesonide inhalation suspension vials (an inhaled, steroid medication used in the treatment of asthma or chronic obstructive pulmonary disease) dispensed from the pharmacy on 2/18/19 for Resident #102 was stored on the med cart. The box contained one opened, undated foil pouch containing 3 vials of budesonide. Nurse #4 confirmed the observed storage of the budesonide inhalation suspension vials inside of the undated, opened foil pouch.

A review of the manufacturer ' s storage instructions for budesonide inhalation suspension indicated once the foil pouch was opened, the solution should be used within 2 weeks.

A review of Resident #102 ' s Physician Orders revealed there was a current order for 0.5 mg/2ml budesonide suspension to be administered as one premixed unit via nebulizer twice daily.

A follow-up interview was conducted on 4/30/19 at 1:20 PM with Nurse #4. During the interview, the nurse reported he "got rid of" the budesonide vials in the undated, opened foil pouch.

An interview was conducted on 4/30/19 at 3:49 PM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the observations of the medication storage on the med carts were discussed. When asked, the DON stated she would expect nursing

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F 761	Continued From page 31	F 761		

staff to date the foil pouch of nebulizer solutions and to follow the manufacturer ' s instructions to determine the shortened expiration date of opened pouches. The DON added, "When in doubt, pitch it."

3) Accompanied by Nurse #3, an observation was made on 4/30/19 at 9:44 AM of the 400 Hall medication cart. The observation revealed an opened bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) was stored lying down on its side in a drawer of the medication cart. The eye drops were labeled for use by Resident #64 and dispensed from the pharmacy on 3/29/19. A handwritten notation on the bottle indicated it was opened on 4/2/19. The manufacturer ' s storage instructions printed on the label of the eye drops read in all capital letters, "Store Upright."

A review of Resident #64's Physician Orders revealed there was a current order for 1% prednisolone ophthalmic suspension to be administered as one drop in the right eye twice daily for glaucoma.

A follow-up interview was conducted on 4/30/19 at 1:50 PM with Nurse #3. During the interview, the nurse reported the prednisolone eye drop bottle was now placed inside another container to ensure it "sat up" (upright) on the med cart.

An interview was conducted on 4/30/19 at 3:49 PM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the observations of the medication storage on the med carts were discussed. When asked, the DON stated she would expect nursing staff to store the prednisolone eye drops correctly

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F 761	Continued From page 32 in accordance with the manufacturer ' s instructions.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to (1) resident rights related to dignity and (2) quality of care which resulted in repeat citations at F550 and F641. The repeated citations of F550 and F641 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F550: Based on observation, record review and staff and resident interview, the facility failed to maintain dignity by failing to knock on resident room doors and announce their presence before entering resident rooms for 6 of 18 residents observed for dignity. Review of the facility's survey history revealed F550 was cited during a 03/22/2018 annual recertification survey and was cited during the	F 867	F 867 QAPI/QAA Improvement Activities On 5/23/19 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, maintenance director, dietary manager, staff facilitator, social worker, admissions coordinator, medical records, and housekeeping supervisor related to the appropriate functioning of the Quality Assurance and Performance (QAPI)Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F550 Resident Rights, F641 Accuracy of Assessments. As of 5/23/19, after the facility consultant in-service, the facility QI Committee will begin identifying other areas of quality concern through the QI review process, for example: preventing recurrence of	6/4/19

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F 867	Continued From page 33 current 05/02/2019 annual recertification and complaint survey. F641: Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set-a tool used for resident assessment) in the areas of Preadmission Screening and Resident Review (PASRR); Active diagnoses, and Medications for 3 of 30 residents (Resident #49, Resident #77, and Resident #82) reviewed for MDS accuracy. Review of the facility's survey history revealed F641 was cited during a 03/22/2018 annual recertification survey and was cited during the current 05/02/2019 annual recertification and complaint survey. An interview was conducted on 05/02/2019 at 11:00 AM with the Administrator. She reported the QA committee met monthly to review performance improvement plans. Review of facility QA documents showed the committee met regularly and reviewed and addressed numerous resident care issues.	F 867	deficient practices related to resident rights, resident dignity, quality if care, reviewing processes, using rounds tools, reviewing resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The QAPI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F550 Resident Rights and F641 Accuracy of Assessments as reflected in the plan of correction. The QAPI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.	