

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105
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F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to respond to grievances for 1 of 3 sampled residents that report missing parts from his wheelchair (Resident #52).</p> <p>The findings included:</p> <p>Resident #52 was admitted to the facility on 9/19/12. The diagnoses included pressure ulcer (multiple), neurogenic bladder, abdominal wound, small bowel obstruction, multiple contractures and paraplegia. The Minimum Data Set (MDS) dated 8/5/14 indicated that Resident #52 's cognition and decision making skills were intact. Resident #52 required total assistance with activities of daily living, with some ability to perform some personal/hygiene care. The primary mode of transportation was the use of a wheelchair.</p> <p>Review of care plan dated 8/7/14 identified the problem pressure ulcers due to paralysis, decrease mobility and preference to stay in positions for prolonged periods of time. The goal included current pressure ulcers would have signs of healing as evidence by wound reports. The approaches included supplements as ordered, reinforcement of education for turning</p>	F 166	<p>F 166</p> <p>Oak Forest Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 9/17/14. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.</p> <p>United Seating and Mobility was contacted on 8/20/14 to set up an appointment for evaluation of Resident #52's wheelchair for replacement of the arm and foot rest of the chair. The wheelchair was evaluated on 8/26/14 by United Seating and Mobility for the replacement of arm and foot rest. The arm and foot rest was ordered on 9/15/14. The facility is awaiting delivery of said items. A ROHO cushion was ordered for Resident #52's wheelchair on 9/8/14 and received on 9/10/2014.</p>	9/17/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/12/2014
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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 166	<p>Continued From page 1</p> <p>and repositioning and pressure relief mattress and wheelchair cushion at all times. Ensure wheelchair cushion for pressure relief in place before transferring to wheelchair.</p> <p>During an observation on 8/18/14 at 10:40AM, Resident #52 wheelchair was located in the room with a flat black cushion and arm/leg rest missing on the left side. When the cushion was pressed down the frame could be felt through the cushion and the black seat surface. There was no inflation within the cushion. There was an area located at the back of the cushion where it could be filled with air. The sealant from the area was missing from the cushion.</p> <p>During an interview on 8/18/14 at 10:40AM, Resident #52 indicated upon admission to the facility in 2012 he had his own wheelchair that was specific to his body and conditions. The wheelchair included a special cushion since he had wounds to hip and bottom area and both arm/leg rest. Resident #52 further stated that when he went out to the hospital several times between April/May and August of 2013, he verbally reported to the administrative staff, social worker, nursing and therapy that his specific cushion for his wheelchair and arm/leg rest on left side were missing. Resident#52 reported that therapy attempted to put arm/leg rest on the chair that belonged to a different type of chair that would not fit. Therapy indicated that he would be reevaluated for a new chair but no-one had been to assess or evaluated since he was told in May 2013. He added that several request had been made by the physician to obtain a specific cushion and wheelchair, however that had not been done as of this date. The current cushion in the chair had been flat and hard since it was</p>	F 166	<p>In-house oriented residents will be interviewed by Department Heads regarding grievances and resolution of concerns by 9/17/14. Any unresolved grievance identified will be communicated to the appropriate team member for investigation and resolution, and will be incorporated into the plan of care as necessary. A resident satisfaction survey will be utilized.</p> <p>100% of the facility staff will be re-trained on the Grievance and Concern Policy by the Assistant Administrator and Staff Development Coordinator by 9/15/14 regarding the grievance process, completion of the Grievance Form, grievance investigation, timely resolution of the grievance and reporting resolution to the Resident/Representative.</p> <p>A resident satisfaction survey was developed and will be in the facility <input type="checkbox"/>s Quality Assurance Performance Improvement process. The resident satisfaction survey will address whether a grievance/concern had been reported, timely resolution of the grievance/concern, reporting the resolution to the resident/representative, and satisfaction with the resolution. Ten (10) total randomly selected oriented residents will be interviewed by Department Heads weekly x4 weeks and monthly thereafter on-going. Any issues identified will be reported to the appropriate department for immediate follow up.</p>		

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F 166	<p>Continued From page 2</p> <p>given to him several months ago and it was not the proper cushion for the chair. Resident #52 indicated that when seated in the chair the cushion goes straight down to the frame and it hurt. Resident #52 reported being frustrated and angry that he could not get what he needed to promote the healing process of his wounds. In addition, he had reported the condition of the wheelchair to several of the facility staff and no-one respected him enough to get the equipment he needed. Resident#52 reported using the wheelchair only during leave of absences from the facility, but when he returned his wounds were worst each time due to the condition of the wheelchair and a cushion that did not properly fit the chair along with missing arm/leg rest. In addition, Resident #52 indicated it should not have taken 7 months to get the proper cushion and wheelchair repairs.</p> <p>Review of the Guest Satisfaction, concern suggestion form dated 4/18/13, revealed Resident#52 initial report of the missing cushion arm/leg rest following a return from the hospital stay. Review of the investigation documented that Resident#52 was admitted without the cushion and only one arm/leg rest on the wheelchair per facility service manager and therapy. Resolution concluded that Resident #52 was offered a facility wheelchair, but declined due to preference for the use of his own chair with a specific cushion and the correct replacement parts of the original wheelchair that was intact prior to hospitalization. There was no further documentation or inventory of the condition of the wheelchair upon admission which indicated the wheelchair was missing a cushion and/or arm/leg rest at the time of admission or in the past two years until reported 4/8/2013.</p>	F 166	<p>The Administrator will review all satisfaction surveys weekly and direct/initiate action plans as trends and issues are identified. A summary of these findings, trends, and interventions to correct will be reported to the Quality Assurance Performance Improvement Committee at least quarterly for review and recommendations.</p> <p>All corrective action will be completed on or before 9/17/14.</p>		

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F 166	<p>Continued From page 3</p> <p>Review of the physician ' s ordered dated 5/8/13, revealed replace wheelchair cushion (Roho) and air fluidized bed. Additional orders written on 7/15/14 and 8/7/14, revealed a standard wheelchair with cushion.</p> <p>Review of the occupational weekly progress dated: 5/15/13, revealed that Resident #52 declined to get into wheelchair due to missing footrest, arm rest and cushion. The note indicated that the left foot rest for wheelchair was located. The parts number for the arm rest was obtained since the arm rest could not be located. There was no further documentation that the order was placed for the arm rest. There was also no further documentation of a revaluation for a new wheelchair or the missing arm/leg rest was replace based on the parts order obtained by therapy.</p> <p>Review of physical therapy evaluations dated 11/7/13: Resident #52 was alert and oriented paraplegia individual that was a long term care that was bed bound and occasionally sits in a wheelchair for less than 15 minutes. Resident #52 had lower extremity contractures (knee extension and left hip extensions, decreased global strength, poor balance, and postural awareness, decreased safety awareness. Resident #52 he required skilled PT to address lower extremity range of motion, sitting balance and wheelchair propulsion to increase environment interaction and quality of life. Resident #52 had excellent potential to meet set the short and long term goals. Resident#52 would tolerate sitting in wheelchair with correct postural alignment for greater than 4 hours and able to weight shift in w/c to increase environment</p>	F 166			

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F 166	<p>Continued From page 4</p> <p>interaction. Short tem goals included Resident #52 would demonstrate weight shifting in his wheelchair with minimum assistance to decrease sustained pressure to sacrum for wound care. He would propel his wheelchair for greater than 150 feet with completed to increase environmental interaction to increase quality of life.</p> <p>Review of the physical therapy discharge summary dated 11/13/13, revealed that Resident #52 was evaluated for positioning and wheelchair adjustments, bilateral lower extremity range of motion to address contractures. He was discharged from physical therapy services due to medical recommendation for wound care conditions. There was no further indication that Resident#52 cushion or arm/leg rest had been replace or repaired. Resident#52 had not been re-evaluated since last assessment.</p> <p>During an interview on 8/18/14 at 3:47PM, Nurse #3 indicated that Resident #52 had spoken with her several times about getting the proper cushion for his wheelchair due being uncomfortable on the wounds. Nurse#3 indicated that she was uncertain of the kind of cushion that was provided for Resident#52 since she had not checked the condition of the cushion. Nurse#3 added that the arm/leg rest had been missing for awhile, not sure of what happen to them.</p> <p>During an observation on 8/19/14 at 8:20AM and 9:40AM, the seat cushion remained flat without air that was located in the seat of the wheelchair. Resident #52 stated that the cushion had been in the same condition since it was given to him back in April or May. His bottom would hurt that is why</p>	F 166			

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F 166	<p>Continued From page 5</p> <p>he did not like to get in the chair and he had to use that chair and cushion when he went out on home visits.</p> <p>During an interview on 8/19/14 at 3:00PM, the social worker (SW) indicated that she had been made aware of Resident#52's wheelchair missing the arm rest /leg resident by previous SW since the end of last year. She indicated that she did not address the current wheelchair issue since she was working on a chair for discharge which was pending at this time. She added that therapy was responsible for repairs/replacement of wheelchair parts. The grievance should have been addressed within a couple of days per policy.</p> <p>During an observation on 8/19/14 at 3:40PM, the occupational, physical therapy staff, interim administrator and Resident #52 present during the check of the type of wheelchair cushion currently in chair. The physical therapist indicated that the current cushion was like the cushion ordered by the physician. The therapist pressed down on the cushion and confirmed the cushion had no air and flat to the surface of the chair and did not provide proper support to protect Resident#52 wounds PT indicated that the therapy department was unaware the cushion had no air and the expectation would be the nursing assistants would report to therapy that the cushion needed air. Resident#52 stated to the physical therapist that was the condition of the cushion when it was presented to him several months ago. Resident #52 further stated at the time of receipt of the cushion it was reported to the therapist the cushion was not the correct one for the wheelchair and it was flat at that time. Resident #52 also indicated to the therapy</p>	F 166			

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F 166	<p>Continued From page 6</p> <p>department staff and interim administrator that he had also not been evaluated or reassessed for a new wheelchair as discussed back in May 2013, nor had the arm/leg rest for the current chair been repaired or replaced as discussed several months ago. The interim administrator stated to Resident #52 that he would be reassessed for an appropriate wheelchair.</p> <p>During an interview on 8/20/14 at 12:40PM, NA#5 indicated that Resident#52 had been complaining about the missing parts to his wheelchair for sometime to several of the staff. She indicated that she had seen the cushion was flat/gel but was not aware that it needed air in it because some of the cushions are just gel.</p> <p>During an interview on 8/20/14 at 12:50PM, the facility service manager indicated some time in the middle of last year there was a discussion about Resident #52 wheelchair missing some parts and that therapy would order the new parts. He indicated that he was not directly involved in the process after it was discussed. The facility service manager indicated the first time he heard about the wheelchair parts were still missing and the cushion did not have any air in it was on 8/19/14 when he filled up the cushion. He added that he had not attempted to repair or replace any parts of the wheelchair because he was not made aware that he needed to do anything with the resident's chair.</p> <p>During a follow-up interview on 8/21/14 at 10:45AM, the interim administrator indicated that she had spoke with Resident#52 sometime last year about the wheelchair grievance and at the time the resident did not want the type of cushion that was being offered to him, therefore she</p>	F 166			

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F 166	Continued From page 7 ordered another type that was similar to the one the physician previously ordered. She indicated that she was aware of the missing parts of the wheelchair. She was unaware that the current cushion did not have the proper inflation. She indicated the grievance should have been resolved long before now, typically within a few days. She added that a new assessment should have been done for the resident to determine the appropriate wheelchair. She reviewed the physician order dated 7/15/14 which indicated that the resident should have a standard wheelchair and roho cushion. She further stated Resident#52 needed a wheelchair assessment due to physical condition and the standard wheelchair may not be appropriate. The situation should have been resolved several months ago.	F 166			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to ensure that a wheelchair cushion was properly inflated and wheelchair arm and foot rest were available for 1 of 1 sampled residents with pressure wounds(Resident #52). The findings included	F 246	The current cushion in Resident #52's wheelchair was inflated during the time of survey. United Seating and Mobility was contacted on 8/20/14 to set up an appointment for evaluation of Resident #52's wheelchair	9/17/14	

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F 246	<p>Continued From page 8</p> <p>Resident #52 was admitted to the facility on 9/19/12. The diagnoses included pressure ulcer (multiple), neurogenic bladder, abdominal wound, small bowel obstruction, multiple contractures and paraplegia. The Minimum Data Set (MDS) dated 8/5/14 indicated that Resident #52 ' s cognition and decision making skills were intact. Resident #52 required total assistance with activities of daily living, with some ability to perform some personal/hygiene care. The primary mode of transportation was the use of a wheelchair.</p> <p>Review of the physician ' s ordered dated 5/8/13, revealed replace wheelchair cushion (Roho) and air fluidized bed. Additional orders written on 7/15/14 and 8/7/14, revealed a standard wheelchair with cushion.</p> <p>Review of physical therapy evaluations dated 11/7/13: Resident #52 was alert and oriented paraplegia individual that was a long term care that was bed bound and occasionally sits in a wheelchair for less than 15 minutes. Resident #52 had lower extremity contractures (knee extension and left hip extensions, decreased global strength, poor balance, and postural awareness, decreased safety awareness. Resident #52 he required skilled PT to address lower extremity range of motion, sitting balance and wheelchair propulsion to increase environment interaction and quality of life. Resident #52 had excellent potential to meet set the short and long term goals. Resident#52 would tolerate sitting in wheelchair with correct postural alignment for greater than 4 hours and able to weight shift in w/c to increase environment interaction. Short tem goals included Resident</p>	F 246	<p>for replacement of the arm and foot rest of the chair. The wheelchair was evaluated on 8/26/14 for replacement of arm and foot rest. The arm and foot rest was ordered on 9/15/14. The facility is awaiting delivery of said items. A ROHO cushion was ordered for Resident #52's wheelchair on 9/8/14 to replace the current cushion and was delivered 9/10/2014.</p> <p>An audit will be completed by the Nursing Administration of all residents' wheelchairs by 9/15/14 to determine if current chairs are appropriate and functioning properly. Cushions will be replaced or inflated as needed.</p> <p>100 % of the nursing and therapy staff will be in-serviced by the Staffing Development Coordinator and Unit Coordinators by 9/17/14 regarding inspection of wheelchairs and cushions prior to placing residents in chair. Inspection will include reporting of missing parts, improper cushions, and improper inflation of a cushion on a Concern/Grievance form that is forwarded to the appropriate team member.</p> <p>A random audit will be completed by Unit Coordinators of ten (10) wheelchairs per month for three (3) months that all wheelchair parts and appropriate cushions are present and cushions are properly inflated. Wheelchair parts will be obtained as needed, cushions will be replaced as needed and cushions will be inflated as needed.</p>		

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F 246	<p>Continued From page 9</p> <p>#52 would demonstrate weight shifting in his wheelchair with minimum assistance to decrease sustained pressure to sacrum for wound care. He would propel his wheelchair for greater than 150 feet with completed to increase environmental interaction to increase quality of life.</p> <p>During an observation on 8/18/14 at 10:40AM, Resident #52 wheelchair was located in the room with a flat black cushion and arm/leg rest missing on the left side. When the cushion was pressed down the frame could be felt through the cushion and the black seat surface. There was no inflation within the cushion. There was an area located at the back of the cushion where it could be filled with air. The sealant from the area was missing from the cushion.</p> <p>During an observation on 8/19/14 at 8:20AM and 9:40AM, the seat cushion remained flat without air that was located in the seat of the wheelchair. Resident #52 stated that the cushion had been in the same condition since it was given to him back in April or May. His bottom would hurt that is why he did not like to get in the chair and he had to use that chair and cushion when he went out on home visits.</p> <p>During an observation on 8/19/14 at 3:40PM, the occupational, physical therapy staff, interim administrator and Resident #52 present during the check of the type of wheelchair cushion currently in chair. The physical therapist indicated that the current cushion was like the cushion ordered by the physician. The therapist pressed down on the cushion and confirmed the cushion had no air and flat to the surface of the chair and did not provide proper support to protect Resident#52 wounds PT indicated that the</p>	F 246	<p>Results of those audits will be presented to the Quality Assurance Performance Improvement Committee at least quarterly for review and recommendations.</p> <p>All corrective action will be completed on or before 9/17/14.</p>		

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

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F 246	<p>Continued From page 10</p> <p>therapy department was unaware the cushion had no air and the expectation would be the nursing assistants would report to therapy that the cushion needed air. Resident#52 stated to the physical therapist that was the condition of the cushion when it was presented to him several months ago. Resident #52 further stated at the time of receipt of the cushion it was reported to the therapist the cushion was not the correct one for the wheelchair and it was flat at that time. Resident #52 also indicated to the therapy department staff and interim administrator that he had also not been evaluated or reassessed for a new wheelchair as discussed back in May 2013, nor had the arm/leg rest for the current chair been repaired or replaced as discussed several months ago. The interim administrator stated to Resident #52 that he would be reassessed for an appropriate wheelchair</p> <p>During an interview on 8/20/14 at 12:50PM, the facility service manager indicated some time in the middle of last year there was a discussion about Resident #52 wheelchair missing some parts and that therapy would order the new parts. He indicated that he was not directly involved in the process after it was discussed. The facility service manager indicated the first time he heard about the wheelchair parts were still missing and the cushion did not have any air in it was on 8/19/14 when he filled up the cushion. He added that he had not attempted to repair or replace any parts of the wheelchair because he was not made aware that he needed to do anything with the resident's chair.</p> <p>During a follow-up interview on 8/21/14 at 10:45AM, the interim administrator indicated that she was aware of the missing parts of the</p>	F 246			

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F 246	Continued From page 11 wheelchair. She was unaware that the current cushion did not have the proper inflation. She added that a new assessment should have been done for the resident to determine the appropriate wheelchair. She reviewed the physician order dated 7/15/14 which indicated that the resident should have a standard wheelchair and roho cushion. She further stated Resident#52 needed a wheelchair assessment due to physical condition and the standard wheelchair may not be appropriate. The situation should have been resolved several months ago.	F 246			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interview the facility failed to ensure that the medication error rate was 5% or below as evidenced by three (3) errors of 26 opportunities resulting in an error rate of 11.5%. The findings included: 1. The Manufacturer ' s Prescribing Information for Ditropan XL (oxybutynin chloride) Extended Release Tablets must be swallowed whole with the aid of liquids, and must not be chewed, divided, or crushed. Resident # 202 was admitted on 10/15/13 and readmitted on 2/21/14. Cumulative diagnoses included dementia, muscle weakness and hypertension. The Quarterly Minimum Data Set dated 7/23/14	F 332	The medication nurse (#1) for resident #202 was counseled and in-serviced by the Director of Nursing on 8/21/14 regarding guidelines for breaking or crushing medications. The resident is now getting the medication as ordered by the physician and recommended by manufacturer. The medication nurse (#2) for resident #27 was counseled and in-serviced by the Director of Nursing on 8/21/14 regarding checking the available dose against the ordered dose prior to administration and notifying the physician to obtain proper orders prior to medication administration.	9/17/14	

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F 332	<p>Continued From page 12</p> <p>revealed Resident #202 was cognitively impaired and always incontinent of urine. Review of the Physician ' s Orders summary for Resident #202, dated 8/1/14 - 8/31/14, revealed an order for Oxybutynin 10 mg Ditropan XL 10 mg (milligrams), one tablet by mouth every day " do not crush ". This medication is used in the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency and frequency. On 8/21/14 at 10:44 AM, Resident #202 was observed during the medication pass. Nurse #1 was observed to prepare resident ' s Ditropan XL. She put this medication and the others she was administering in a medication crusher to crush the medications and then poured them in a medication cup. Nurse #1 then stated that she was aware the Dirtropan XL was not supposed to be crushed and that she was careful to only break that medication in half and not crush it. Nurse #1 added that about a year ago the pharmacist told her that because the whole Ditropan XL tablet was too large for the resident to swallow easily it would be fine to break it in half. Nurse #1 stated that an order to break the Ditropan XL in half for Resident #202 was not obtained. She then proceeded to administer the broken Ditropan XL tablet to the resident along with the resident ' s other medications. During interview with Nurse Manager #1 on 8/21/14 at 1:25 PM she indicated that it was her expectation that Nurse #1 would have gotten an order for the Ditropan XL to be broken before administration, or explored other prescribing alternatives with the physician, instead of continuing to break a medication that should be taken whole.</p> <p>2. Resident #27 was admitted on 7/17/14 with cumulative diagnoses including rectal colon</p>	F 332	<p>The resident is now getting the medication as ordered by the physician.</p> <p>The medication nurse (#3) for resident #153 was counseled and in-serviced by the Director of Nursing on 8/21/14 regarding guidelines for medication administration via tube and changes in regulation regarding mixing together cocktailing crushed medications for tube administration. The resident is now getting the medication as ordered by the physician.</p> <p>A medication administration audit was completed by an Administrative Registered Nurse on medication nurse #1 on 9/9/14. The medication nurse was in-serviced by the Administrative Registered Nurse regarding the findings of that audit. The medication nurse will continue to be audited and educated per facilities policy and procedure. A medication administration audit was completed by an Administrative Registered Nurse on medication nurse #2 on 9/2/14. The medication nurse was in-serviced by the Administrative Registered Nurse regarding the findings of that audit. The medication nurse will continue to be audited and educated per facility's policy and procedure. A medication administration audit was completed by an Administrative Registered Nurse on medication nurse #3 on 9/5/14. The medication nurse was in-serviced by the Administrative Registered Nurse regarding the findings of that audit. The medication nurse will</p>		

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F 332	<p>Continued From page 13</p> <p>cancer.</p> <p>Review of the Physician ' s Orders dated 8/1/14 - 8/31/14 revealed an order for Gas Relief 125 mg (milligram) chewtab (house stock), chew and swallow one tablet by mouth 4 times a day.</p> <p>On 8/21/14 at 12:44 PM Resident # 27 was observed during medication pass. Nurse #2 was observed to prepare and administer Resident #27 ' s medications including 1 Gas Relief tablet. The dosage on the bottle of Gas Relief tablets that Nurse #2 prepared and administered to Resident #27 was 80 mg.</p> <p>On 8/21/14 at 1:30 PM Nurse #2 was interviewed. She examined the Medication Administration Record for Resident #27 and acknowledged the order was for 125 mg and then examined the Gas Relief bottle she dispensed from and acknowledged it contained 80 mg tablets. Nurse #2 stated that the 80 mg tablets were the only ones available in the facility and she was not aware of a 125 mg dosage. She stated that she would contact the physician and have the order changed.</p> <p>3. Review of the facilities General Guidelines for Administering Medication via Enteral Feeding Tube, dated January 2014, revealed that medications were to be given with a 50 ml water flush before and after medications as well as a 5 ml flush between medications.</p> <p>Resident # 153 was admitted on 4/25/14 and readmitted on 8/20/14 with cumulative diagnoses including hypertension and seizures. She also had a gastrostomy tube (G-tube).</p> <p>Review of the Physicians Orders dated 8/20/14 revealed that Resident #153 had the following medications order to be given at noon daily: Metoprolol Tartate (Lopressor) 25 mg (milligrams) 1 tablet per G-tube every 6 hours. Valproic Acid (Depakene) 250/mg /5 ml (milliliter)</p>	F 332	<p>continue to be audited and educated per facilities <input type="checkbox"/> policy and procedure.</p> <p>Medication Administration guidelines were added to the Medication Administration Record Books by the Director of Nursing on 9/1/14. An in-service will be held for 100% of licensed nurses and medication aides on 9/15/14 through 9/17/14 by the Director of Nursing regarding medication administration, guidelines for breaking or crushing medications, and guidelines for medication administration via tube and changes in regulation regarding mixing together cocktailing crushed medications for tube administration. A Best Practice Guidelines for Medication Administration test will be administered to the licensed nurses and medication aides. The nurses and med aides who fail the test, will be audited by an Administrative Registered Nurse and educated per facilities <input type="checkbox"/> policy and procedure as needed.</p> <p>The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee at least quarterly for review and recommendations.</p> <p>All corrective action will be completed on or before 9/17/14.</p>		

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F 332	Continued From page 14 per G-tube every 6 hours. Hydralazine (Apresoline) 100 mg 1 tablet per G-tube every 6 hours. There was also an order to flush the G-tube with 50 ml water before and after medication administration. On 8/21/14 at 12:44 PM Resident # 153 was observed during medication pass. Nurse # 3 was observed to prepare the above medications, the Lopressor and Apresoline were crushed together and approximately 15 ml of water was added to dissolve them. The Valproic Acid was also diluted in a separate medication cup with water. After Nurse #2 checked the G-tube for placement she flushed with 50 ml of water and then administered the Valproic Acid, Lopressor and Apresoline per G-tube without flushing with 5 ml fluids in between each medication. She then flushed the G-tube with another 50 ml water. Nurse #3 was interviewed at this time. She stated that she did not flush between medications because she was sure the resident had an order to cocktail medications on her chart. She then stated that the resident had just been readmitted and might not yet have that order but she believed the Physician would want the resident ' s medications given together without flushing between. Nurse #3 said she was aware that giving medications per G-tube without flushing between required a Physician ' s order and a physician written rationale specific to the resident. The Director of Nursing was interviewed on 8/21/14 at 4 PM. She stated that the Physician had been contacted and that he did want Resident #153 ' s medications cocktailled to prevent fluid overload. She stated that Nurse #3 had used her own judgment in deciding not to flush between the medications but that she should have contacted the physician first.	F 332			

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F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain sanitary conditions in the kitchen by not 1) ensuring that foods were labeled and dated in 1 of 1 walk in freezer, 2)ensuring that spoiled/rotten produce was removed from fresh produce in 1 of 1 walk in refrigerators 3) Clean and remove the food debris and grease from the hot plate warmer, dried food and liquids from the ice cream box and 1 refrigerator cooler 4) clean and remove dried food debris from 5 dry food storage containers. The findings included:</p> <p>1. During an observation of the walk in freezer on 8/18/14 at 10:00AM, the following items were opened on shelves unlabeled and undated, a box of mixed vegetables and bag of corn.</p> <p>During an interview on 8/18/14 at 10:00AM, the dietary manager (DM) identified the mixed vegetables and corn and indicated that any of the dietary staff that opens a product should label and dated the item before it was returned to the refrigerator.</p>	F 371	<p>Improperly labeled food items and spoiled produce were discarded at the time of survey. The hot plate warmer, ice cream box, refrigerator cooler, and dry food storage containers were cleaned at the time of survey.</p> <p>All dietary staff will be in-serviced by the Dietary Manager regarding food storage and sanitation guidelines and their professional responsibilities by 9/15/14.</p> <p>Daily produce inspections will be implemented to ensure fresh produce. Spoiled produce will be removed immediately. All foods will be dated and labeled with a permanent marker and/or food label prior to stocking. A cleaning schedule will be developed and utilized to ensure food debris and grease are removed. This schedule includes the hot plate warmer, ice cream box, cooler, and dry food storage containers. These inspections and implementation will be</p>	9/17/14	

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F 371	<p>Continued From page 16</p> <p>During an interview on 8/20/14 at 11:40AM, Cook#1 indicated that she was responsible for ensuring that all foods were labeled/dated She added that she must complete the kitchen check list which include food/labeling/dating, proper storage of foods, stocking of produce..</p> <p>During an interview on 8/20/14 at 11:55AM, Cook#2 indicated that she was responsible for ensuring that all food items were dated/labeled and sealed properly before they are stored. She indicated upon entry of the shift she would review her checklist and check the refrigerators for foods in preparation for the meal.</p> <p>2. during an observation of the walk in refrigerator on 8/18/14 at 10:00AM, had 2 boxes of fresh cucumbers which contained cucumbers that were mushy and molded. Also a box of fresh celery that contained celery that was rotten and wilted with brown stalks.</p> <p>During and interview on 8/18/14 at 10:00AM, the DM identified the produce and stated the produce should be rotated and checked daily. The produced should be discarded once discovered.</p> <p>During an interview on 8/20/14 at 11:40AM, Cook#1 indicated that she was responsible for ensuring that all foods were checked and rotten produce removed from fresh produce.</p> <p>During an interview on 8/20/14 at 11:55AM, Cook#2 indicated that she was responsible for ensuring that no rotten produce be stored with fresh produce. The produce should be discarded immediately once checked before it was put on</p>	F 371	<p>completed by the Dietary Manager and/or Assistant Dietary Manager. Issues of non-compliance will be corrected immediately and dietary staff will be educated per facility policy and procedure.</p> <p>A QAPI audit tool will be implemented to monitor food storage and sanitation issues. The Dietary Manager, Assistant Dietary Manager, Administrator and/or Assistant Administrator will complete food storage and sanitation rounds with findings documented on the QAPI audit tool at an minimum of 3x per week for 4 weeks and weekly thereafter, ongoing. Issues of non-compliance will be corrected immediately at the time of the audit. All findings will be forwarded to the Dietary Manager for follow-up intervention. A summary of trends and/or issues of non-compliance will be discussed by the Dietary Manager, Administrator, and Assistant Administrator weekly x4 weeks and monthly thereafter, on-going. Further re-training or disciplinary action will be implemented as appropriate.</p> <p>The Administrator and/or Assistant Administrator will review all QAPI Sanitation Audit results monthly. A summary of these findings, trends, and interventions to correct will be reported to the Quality Assurance Performance Improvement Committee at least quarterly for review and recommendations.</p> <p>All corrective action will be completed on or before 9/17/14.</p>		

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F 371	<p>Continued From page 17 the shelf.</p> <p>3. During an observation on 8/18/14 at 10:00AM, hot plate warmer, ice cream box and a refrigerator cooler was dirty and had a large volume of grease and food/liquid build up on the inside and outsides of the units.</p> <p>During an interview on 8/18/14 at 10:00AM, the DM indicated that the hot plate warmer, ice cream box and refrigerator cooler were cleaned every three weeks. The cooks were responsible completing the daily checklist which included the daily cleaning of the outside and bottom surfaces of all kitchen appliances</p> <p>During an interview on 8/20/14 at 11:40AM, Cook#1 indicated that she was responsible for ensuring that all ovens, hot box, refrigerators, steam table, ice cream box, storage bins are cleaned and wipe down after her shift. She added that she must complete the kitchen check list which included cleaning of all food equipment.</p> <p>During an interview on 8/20/14 at 11:55AM, Cook#2 indicated that she was responsible for ensuring that all of the food equipment be cleaned thoroughly by the end of the shift and complete the checklist.</p> <p>4. During an observation on 8/18/14 at 10:00AM, the 5 dry storage bins had large volumes of dried foods and liquids located on the inside and outside of the containers.</p> <p>During an interview on 8/18/14 at 10:00AM, the DM indicated that the cooks were responsible for ensuring that all surfaces in the kitchen were</p>	F 371			

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F 371	<p>Continued From page 18 wiped down and cleaned daily and part of the completion of the kitchen checklist.</p> <p>During an interview on 8/20/14 at 11:40AM, Cook#1 indicated that she was responsible for ensuring that all ovens, hot box, refrigerators, steam table, ice cream box, storage bins are cleaned and wipe down after her shift. She added that she must complete the kitchen check list which included cleaning of all food equipment.</p> <p>During an interview on 8/20/14 at 11:55AM, Cook#2 indicated that she was responsible for ensuring that all of the food equipment be cleaned thoroughly by the end of the shift and complete the checklist.</p>	F 371			