| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint survey was conducted on 01/22/19-01/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 9ZV411. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>No deficicencies were cited as a result of this complaint investigation. Event ID 9ZV411. | F 000 | | |
| F 636 SS=E | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status. | F 636 | | 2/20/19 |

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

Electronically Signed | 02/14/2019

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| F 636 | Continued From page 1<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete the Nutrition Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 5 of 13 residents sampled for nutrition and/or food | F 636 | --Residents who had a Care Area Trigger for nutrition on their annual MDS identified as affected by the reported deficient practice. The reported evidence of deficient practice stated that the | |

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| F 636 | Continued From page 2<br>concerns (Residents #6, #31, #77, #84, and #85).<br><br>The findings included:<br><br>1. Resident #6 was admitted to the facility on 08/10/15. Her diagnoses included chronic pain syndrome, degenerative disease of the nervous system, unspecified mood affective disorder and adult failure to thrive.<br><br>The annual Minimum Data Set dated 07/18/18 coded Resident #6 as having unclear speech, being severely cognitively impaired, having no moods or behaviors, being nonambulatory and requiring extensive to total assistance with all activities of daily living skills including eating. She was also coded as having a swallowing disorder and receiving a mechanically altered diet.<br><br>The Care Area Assessment (CAA) for nutrition was dated 07/18/18. This CAA consisted of a check list of indicators that affect her ability to eat, her mental status, diseases and conditions, and antipsychotic medications. Under the analysis of findings was the only narrative which stated Resident #6 "is at risk for weight/nutrition issues due to puree diet and reduced ADL (activities of daily living) performance. (Resident name) is confined to wheelchair and requires extensive assistance with all activities." The information did not include Resident #6's strengths or weaknesses or any specific reason these issues posed a risk to her nutrition.<br><br>Interview with the Dietary Manager, who wrote this CAA, occurred on 01/25/19 at 11:41 AM. The Dietary Manager stated he had been employed 3 years as the dietary manager at this facility. He stated he was trained by a previous MDS | F 636 | information did not include resident #6, 31, 84, 85, 77's "strengths or weaknesses or any specific reason the issues posed a risk to his/her nutrition". No corrective action will be completed for the identified residents because the care plan, interventions, and orders were in place and appropriate. Sending an MDS correction will not change the RUG score or care already provided.<br><br>-- Every resident who has a Care Area Trigger for nutrition is identified as potentially being affected by the reported deficient practice.<br><br>-- Education to be provided to the interdisciplinary team on being resident specific on CAAs, documenting the "strengths or weaknesses or any specific reason the issue posed a risk" to the triggered area. This education to be completed by 2/19/2019.<br><br>-- Audits to be completed twice weekly for two weeks,then weekly for four weeks, and then as needed. The audits will consist of review of one random MDS completed that day to ensure CAAs document the strengths or weaknesses or any specific reason the issue posed a risk. Audits will be completed by the Director of Nursing or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings for the next three months to ensure compliance is maintained. The next meeting is 2/19/2019. Overall completion date will be 3/29/19. | |

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| F 636 | Continued From page 3 | F 636 | | |

coordinator on what to include in a CAA. He stated that he reviewed the predetermined categories, clinical diagnoses and would review nursing notes. He stated that under the analysis for nutrition he was instructed to write a brief summary of the populated items on the CAA that may affect nutrition or weight which was what this CAA reflected.

The Administrator was interviewed on 01/25/19 at 1:30 PM. The Administrator stated that he believed the analysis on the CAA met the Resident Assessment Instrument manual instructions and that the CAA didn't have to be detailed.

2. Resident #31 was admitted to the facility most recently on 11/08/18. Her diagnoses included pneumonia, diabetes, anxiety and gastro esophageal reflux disease.

Her admission Minimum Data Set dated 11/16/18 coded her as having intact cognition, eating independently and receiving a therapeutic diet.

The Care Area Assessment for nutrition dated 11/16/18 consisted of a check list with impairments that could affect her ability to eat, her having anxiety problems, and diagnoses and conditions. The narrative under analysis of findings stated "Reduced ADL (activities of daily living) performance and dx (diagnoses) list items can affect nutrition and weight." The information did not include Resident #31's strengths or weaknesses or any specific reason these issues posed a risk to her nutrition.

Interview with the Dietary Manager, who wrote this CAA, occurred on 01/25/19 at 11:41 AM. The

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| F 636 | Continued From page 4 | F 636 | | |

Dietary Manager stated he had been employed 3 years as the dietary manager at this facility. He stated he was trained by a previous MDS coordinator on what to include in a CAA. He stated that he reviewed the predetermined categories, clinical diagnoses and would review nursing notes. He stated that under the analysis for nutrition he was instructed to write a brief summary of the populated items on the CAA that may affect nutrition or weight which was what this CAA reflected.

The Administrator was interviewed on 01/25/19 at 1:30 PM. The Administrator stated that he believed the analysis on the CAA met the Resident Assessment Instrument manual instructions and that the CAA didn't have to be detailed.

3. Resident #84 was admitted to the facility on 03/27/14 and most recently on 01/03/18. her diagnoses included diabetes, gastro esophageal reflux disease, chronic pain syndrome, depressive disorder, anxiety disorder and disc degeneration.

Her annual Minimum Data Set dated 01/02/19 coded her with moderately impaired cognitive skills, having no behaviors, requiring extensive assistance with eating, having a swallowing disorder and receiving a mechanically altered, therapeutic diet.

The Care Area Assessment for Nutrition dated 01/02/19 consisted of a check list of impairments that may affect her ability to eat, her poor memory and anxiety problems, diseases and conditions, and she was checked as receiving antipsychotic medications. Under the analysis of findings was

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| F 636 | Continued From page 5 | F 636 | | |

the only narrative which stated per her "BMI (body mass index) the resident is obese, Dx (diagnoses) list items can cause issues with nutrition and weight. The information did not include Resident #84's strengths or weaknesses or any specific reason these issues posed a risk to her nutrition.

Interview with the Dietary Manager, who wrote this CAA, occurred on 01/25/19 at 11:41 AM. The Dietary Manager stated he had been employed 3 years as the dietary manager at this facility. He stated he was trained by a previous MDS coordinator on what to include in a CAA. He stated that he reviewed the predetermined categories, clinical diagnoses and would review nursing notes. He stated that under the analysis for nutrition he was instructed to write a brief summary of the populated items on the CAA that may affect nutrition or weight which was what this CAA reflected.

The Administrator was interviewed on 01/25/19 at 1:30 PM. The Administrator stated that he believed the analysis on the CAA met the Resident Assessment Instrument manual instructions and that the CAA didn't have to be detailed.

4. Resident #85 was admitted to the facility on 09/27/18. His diagnoses included intracranial injury with loss of consciousness of unspecified duration, acute pain, paraplegia and quadriplegia, pressure ulcer and pneumonia.

The admission Minimum Data Set dated 10/04/18 coded Resident #85 as being cognitively intact, having some mood issues including sleep and appetite concerns, requiring extensive to total

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| F 636 | Continued From page 6 | F 636 | | |

assistance with all activities of daily living skills including eating, having range of motion impairments on both side upper and lower extremities and having frequently pain. He was coded as receiving a mechanically altered diet.

The Care Area Assessment dated 10/04/18 included a check list which checked some functional impairment that may affect his ability to eat, diseases and conditions, and his receipt of antipsychotic medications. The narrative located under the analysis of findings stated "Reduced ADL (activities of daily living), due to paralysis, mech (mechanical) diet as of this writing. Weight and nutrition can be affected by dx list. Assisted feeding". The information did not include Resident #85's strengths or weaknesses or any specific reason these issues posed a risk to his nutrition.

Interview with the Dietary Manager, who wrote this CAA, occurred on 01/25/19 at 11:41 AM. The Dietary Manager stated he had been employed 3 years as the dietary manager at this facility. He stated he was trained by a previous MDS coordinator on what to include in a CAA. He stated that he reviewed the predetermined categories, clinical diagnoses and would review nursing notes. He stated that under the analysis for nutrition he was instructed to write a brief summary of the populated items on the CAA that may affect nutrition or weight which was what this CAA reflected.

The Administrator was interviewed on 01/25/19 at 1:30 PM. The Administrator stated that he believed the analysis on the CAA met the Resident Assessment Instrument manual instructions and that the CAA didn't have to be

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| F 636 | Continued From page 7 | F 636 | | |

detailed.

5. Resident #77 was admitted to the facility on 03/19/18. Her diagnoses included Hypertension, Non-Alzheimer's Dementia, Anxiety and Depression.

The quarterly Minimum Data Set dated 12/26/18 coded Resident #77 as being severely cognitively impaired, having no moods or behaviors, and requiring extensive two- person assistance with all activities of daily living skills including eating. She was also coded to be receiving a mechanically altered diet.

The Care Area Assessment (CAA) for nutrition was dated 03/27/18. This CAA consisted of a check list of indicators that affect her ability to eat, her mental status, diseases and conditions, and antipsychotic medications. Under the analysis of findings was the only narrative which stated Resident #77 " had a history of reflux and anxiety disorder". The information did not include Resident #77's strengths or weaknesses or any specific reason these issues posed a risk to her nutrition.

Interview with the Dietary Manager, who wrote this CAA, occurred on 01/25/19 at 11:41 AM. The Dietary Manager stated he had been employed 3 years as the dietary manager at this facility. He stated he was trained by a previous MDS coordinator on what to include in a CAA. He stated that he reviewed the predetermined categories, clinical diagnoses and would review

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| F 636 | Continued From page 8<br>nursing notes. He stated that under the analysis for nutrition he was instructed to write a brief summary of the populated items on the CAA that may affect nutrition or weight which was what this CAA reflected.<br><br>The Administrator was interviewed on 01/25/19 at 1:30 PM. The Administrator stated that he believed the analysis on the CAA met the Resident Assessment Instrument manual instructions and that the CAA didn't have to be detailed. | F 636 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) accurately for 2 of 22 residents sampled for MDS accuracy. Resident #85's pressure ulcer section did not accurately reflect the number and type of pressure sores he had on admission and Resident #46's MDS did not accurately reflect weight change.<br><br>The findings included:<br><br>1. Resident #85 was admitted to the facility on 09/27/18. His diagnoses included an intracranial injury, quadriplegia, fusion of the spine, and pneumonia.<br><br>Review of the admission nursing notes dated 09/27/18 at 11:56 PM noted Resident #85 arrived | F 641 | -- Every resident requiring MDS to be completed is identified as potentially being affected by the deficient practice.<br><br>-- Education to be provided to the interdisciplinary team on the importance of double checking all entries on the MDS for accuracy before locking and submitting the MDS. This education to be completed by 2/19/2019. The interdisciplinary team will receive education annually and as needed. They will not be allowed to work after 2/19/2019 until the education is completed.<br><br>-- Audits to be completed twice weekly for two weeks, then weekly for four weeks, and then as needed. The audits will | 2/20/19 |

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| F 641 | Continued From page 9<br>to the facility around 5:45 PM on 09/27/18. The note stated he had eschar noted on the bottom of both feet, a stage 4 decubitus ulcer on the resident's sacrum, both heels were dry and he had edema on both feet. He was noted to be wearing L-Nard boots (used to relieve pressure to heels) to both feet.<br><br>The Wound assessment Reports noted the following 5 areas as being identified on 09/27/18:<br>*A stage 4 was noted to the sacrum with bone exposure measuring 5.0 centimeters (cm) by 4.5 cm by 4.0 cm and noted with granulation, bone and slough.<br>*There was an unstageable area to the right heel measuring 3.5 cm by 5.0 cm by 0.0 cm with the wound bed covered in eschar.<br>*An unstageable area on the right plantar ball of the foot measuring 3.0 cm by 3.5 cm by 0.0 cm covered in black eschar.<br>*On the dorsal outer ball of the left foot was an unstageable wound measuring 1.0 cm by 1.0 cm by 0.0 cm covered in black eschar.<br>*The dorsal inner ball of the left foot was an unstageable area measuring 4.0 cm by 3.0 cm by 0.0 cm covered in black eschar.<br><br>There was a wound assessment note dated 09/28/18 at 12:04 PM describing the above areas in the departmental notes of the resident record.<br><br>On 10/03/18 the wound assessment reports notes these same 5 areas and new measurements including the description that the sacrum was a stage 4 pressure and the other 4 wound on the feet were unstageable.<br><br>The admission Minimum Data Set (MDS), dated 10/04/18, coded Resident #85 as being | F 641 | consist of a review of one random MDS completed that day to ensure no keying errors were made. Audits to be completed by the Director of Nursing or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings for the next three months to ensure compliance is maintained. The next meeting is 2/19/2019. Overall completion date will be 3/29/19. | |

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| F 641 | Continued From page 10 | F 641 | | |

cognitively intact, requiring extensive to total assistance with all activities of daily living, and having 1 stage 4 pressure ulcer and 1 unstageable pressure ulcer due to coverage of wound by slough and/or eschar, both present on admission.

The Care Area assessment (CAA) dated 10/10/18 related to pressure ulcers included that Resident #85 was admitted to the facility with a stage 4 pressure area to his sacrum and DTI (deep tissue injury) to his heels. There was no mention of the other areas noted on his feet.

An interview with the MDS Coordinator was conducted on 01/25/19 at 11:19 AM. She confirmed she completed the MDS and CAA related to pressure ulcer. She presented a report that she used which only listed the stage 4 on his sacrum and an unstageable area on the ball of one foot.

Upon follow up interview with the MDS Coordinator on 01/25/19 at 12:01 PM, she stated that she did not review the wound measurements and notes which were dated 9/28/18 and 10/03/18. She stated that she did not know why all the unstageable areas did not show up on the report she used when completing the MDS. She stated that the physician's history and physical dated 10/02/18 only mentioned the sacrum stage 4 and a blister on his heel. The MDS coordinator stated the MDS was miscoded and did not include all of Resident #85's pressure ulcers.

Interview with the Director of Nursing (DON) on 01/25/19 at 1:29 PM revealed that the MDS inaccurately reflected Resident #85's skin condition on admission and the MDS should be

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| F 641 | Continued From page 11 | F 641 | | |

accurate.

Interview with the Administrator on 01/25/19 at 1:30 PM (present with the DON) revealed the care was provided from the care plan which was what mattered.

2.Resident #46 was admitted to the facility on 06/19/2015 with multiple diagnoses including anemia,
hypertension, hyperlipidemia, non-Alzheimer's dementia.

Review of the quarterly Minimum Data Set (MDS) dated 11/28/18 revealed Resident #46 was coded for having weight loss under Section K for Nutritional Status.

A review of Resident #46 recorded weight revealed a weight of 136 dated 10/10/18 and a weight of 132 dated 11/14/18.

On 01/24/19 at 2:59 PM an interview was conducted with the MDS Coordinator. The interview revealed the Dietary Manager was responsible for completing Section K of the MDS assessment. The interview revealed weight loss had been coded incorrectly for Resident #46.

On 01/25/19 at 8:26AM an interview was conducted with the Dietary Manger. The interview revealed weight loss had been entered in error for Resident #46.

On 01/25/19 at 9:45AM an interview was conducted with the Director of Nursing (DON). The interview revealed she had reviewed the

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| F 641 | Continued From page 12<br>MDS for Resident #46 and had spoken to the MDS Coordinator and Dietary Manager. The interview revealed Resident #46 should have no been coded for weight loss on the 11/28/18 MDS. The interview revealed her expectations were for the MDS to be coded accurately. | F 641 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to follow Physician's orders for wound care for 1 of 3 residents reviewed for pressure ulcers (Resident #17).<br><br>Findings included:<br><br>Resident #17 was admitted to the facility 10/25/18 with diagnoses including hypertension (high blood pressure), thyroid disorder, Alzheimer's disease, and insomnia.<br><br>Review of Resident #17's care plan for skin integrity dated 10/25/18 stated skin treatments were to be administered as ordered. An undated hand written entry on the skin integrity care plan stated Resident #17 had a stage 2 pressure ulcer on her right heel, an unstageable wound to her sacrum, and a stage 2 pressure ulcer to her right buttock.<br><br>Review of the admission Minimum Data Set | F 658 | -- Any resident receiving wound care is identified as potentially being affected by the deficient practice.<br><br>-- Education to be provided to nurses and treatment techs on the six rights of medication administration. This education to be completed by 2/19/2019. Nurses and treatment techs will not be allowed to work after 2/19/2019 until the education is completed. Education will also be provided to new nurses and treatment techs upon hire, and to current staff annually and as needed. No systemic changes are necessary.<br><br>-- Audits to be completed twice weekly for two weeks, then weekly for four weeks, and then as needed. The audits will consist of observations of two treatments performed to ensure orders are followed accurately. Audits to be completed by the | 2/20/19 |

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| F 658 | Continued From page 13<br>(MDS) dated 11/02/18 revealed Resident #17 had moderately impaired cognition and required extensive assistance with bed mobility and transfers. The MDS also stated Resident #17 was at risk for developing a pressure ulcer.<br><br>The pressure ulcer to Resident #17's right heel was identified on 12/19/18 and was classified as a stage 2 pressure ulcer.<br><br>Review of Resident #17's Physician order for the right heel wound dated 12/19/18 were to cleanse the wound with wound cleanser, apply calcium alginate (an absorbent dressing), and cover with a foam dressing every other day and as needed.<br><br>The pressure ulcers to Resident #17's sacrum and right buttock were identified on 12/31/18. The pressure ulcer to Resident #17's sacrum was classified as unstageable. The pressure ulcer to Resident #17's right buttock was classified as a stage 2 pressure ulcer.<br><br>Review of Resident #17's Physician order for the sacral and right buttock wounds dated 12/31/18 were to cleanse the wounds with wound cleanser, apply calcium alginate to the wound beds, and cover with a foam dressing every other day and as needed.<br><br>Observation of the dressing change to Resident #17's right heel on 01/24/19 at 2:15 PM revealed the old dressing was removed, the wound was cleaned with wound cleanser, Triad paste (a wound paste that absorbs wound drainage) was applied to the wound edges, calcium alginate was applied to the wound bed, and the wound was covered with a foam dressing. The dressing was changed by the Treatment Technician with the | F 658 | Director of Nursing or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings for the next three months to ensure compliance is maintained. The next meeting is 2/19/2019. Overall completion date will be 3/29/19. | |

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| F 658 | Continued From page 14 | F 658 | | |

Wound Care Nurse assisting.

Observation of the dressing change to Resident #17's sacral wound and right buttock wound on 01/24/19 at 2:20 PM revealed the old dressing was removed, the wounds were cleansed with wound cleanser, Triad paste was applied to the wound edges, calcium alginate was applied to the wound beds, and the wounds were covered with a foam dressing. The dressings were changed by the Treatment Technician with the Wound Care Nurse assisting.

An interview with the Wound Care Nurse on 01/24/19 at 3:41 PM revealed she thought Resident #17 had an order for Triad paste. The Wound Care Nurse reviewed the wound care orders for Resident #17 during the interview and confirmed there was no Physician's order for the Triad paste. The Wound Care Nurse stated there should have been a Physician's order to use Triad paste for Resident #17's wounds. The Wound Care Nurse further stated she would have told the Treatment Technician prior to her using the Triad if she did not feel it was appropriate for Resident #17 or if she had realized there had not been a Physician's order for the Triad paste. The Wound Care Nurse stated sometimes she changed Resident #17's dressings and sometimes the Treatment Technician changed Resident #17's dressings. The Wound Care Nurse stated she had changed Resident #17's dressings earlier in the week and did not use Triad paste around the wounds.

An interview with the Director of Nursing (DON) on 01/24/19 at 3:48 PM revealed use of Triad paste required a Physician's order. The DON reviewed Resident #17's wound care orders and

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| F 658 | Continued From page 15<br>stated there was no order for Triad paste. The DON stated she would have expected there to have been a Physician's order prior to use.<br><br>An interview with the Physician on 01/24/19 at 4:15 PM revealed Triad paste required a Physician's order for use and he would have expected an order to have been in place prior to use for Resident #17. The Physician indicated he did not anticipate any harm to Resident #17 from the Triad paste application.<br><br>An interview with the Treatment Technician on 01/25/19 at 8:12 AM revealed she made an honest mistake by applying the Triad paste to Resident #17. The Treatment Technician said she just got nervous and got the Triad paste out and applied it to Resident #17 in error. The Treatment Technician stated she had not previously been applying Triad paste to Resident #17. | F 658 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the | F 690 | | 2/20/19 |

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| F 690 | Continued From page 16<br>resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on policy review, observations and staff interviews, the facility failed to handle an indwelling urinary catheter bag during a transfer in a manner to prevent urinary tract infections for 1 of 1 sampled resident who was observed being transferred with a catheter. (Resident #85).<br><br>The findings included:<br><br>Resident #85 was admitted to the facility on 09/27/18. His diagnoses included quadriplegia, intracranial injury, fusion of the spine, bladder disorder and a stage 4 pressure ulcer on his sacrum.<br><br>The admission Minimum Data Set (MDS) dated 10/04/18 coded him as having intact cognition, | F 690 | -- Resident #85 was the only resident affected by the reported deficient practice. Immediate education provided to the staff involved on correct placement of catheter bags during transfers.<br><br>-- Residents who have indwelling catheters and require the total mechanical lift for transfers are identified as potentially being affected by the reported deficient practice.<br><br>-- Education to be provided to all nursing staff (nurses, nursing assistants, treatment techs) on catheter care, and the correct placement of the catheter bag during transfers. This education to be | |

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| F 690 | Continued From page 17<br>requiring total assistance with activities of daily living, having an indwelling urinary catheter, having had a urinary tract infection in the previous 30 days and receiving an antibiotic 7 days in the previous 7 days.<br><br>Review of physician orders dated 01/01/19 revealed a urinalysis and culture and sensitivity was ordered to diagnoses hematuria (blood in the urine). On 01/03/19 the antibiotic Levaquin 750 milligrams (mg) was ordered to be given every day for 5 days for a urinary tract infection.<br><br>The quarterly MDS dated 01/02/19 coded Resident #85 as having moderately impaired cognition, requiring total assistance with activities of daily living , having an indwelling urinary catheter, and having an urinary tract infection in the previous 30 days.<br><br>The care plan, last reviewed 01/10/19, for having an indwelling urinary catheter included interventions to provide pericare as needed, administer medications as ordered, encourage fluids and provide catheter care every shift.<br><br>Review of the physician orders dated 01/21/19 revealed a urinalysis and culture and sensitivity was ordered due to increased confusion and neurogenic bladder for Resident #85.<br><br>On 01/24/19 at 10:28 AM, Nurse Aide (NA) #1 and #2 were observed transferring Resident #85 from the bed to the wheelchair. As the staff were positioning the total lift sling under Resident #85, the catheter bag was placed on the bed next to Resident #85's waist/hip area by NA #1. Once the sling was positioned under him, NA #1 placed the catheter bag inside the lift sling at the waist | F 690 | completed by 2/19/2019. Nursing staff will not be allowed to work after 2/19/2019 until this education is completed. New nursing staff will receive education upon hire. Education will also be completed annually and as needed. No systemic changes are necessary.<br><br>-- Audits to be completed twice weekly for two weeks, then weekly for four weeks, and then as needed. The audits will consist of observations of transfers with residents who have indwelling catheters. Audits to be completed by the Director of Nursing or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings for the next three months to ensure compliance is maintained. The next meeting is 2/19/2019. Overall completion date will be 3/29/19. | |

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| F 690 | Continued From page 18<br>area where it stayed while he was hoisted upright in a sitting position and lowered into the wheelchair. Once situated, the catheter bag was moved to under the wheelchair seat below his bladder.<br><br>During an interview with NA #1 on 01/24/19 at 10:46 AM, NA #1 stated that she always placed the catheter bag next to him inside the sling so that the catheter tubing did not dangle and/or catch on anything during the transfer. She further stated she was not sure about the need to keep the catheter bag below the bladder, she just didn't want it catching on something during the transfer.<br><br>Review of physician orders dated 01/24/19 revealed the physician ordered Rocephin 1 gram every day for 7 days to be administered via intra muscular injection for a urinary tract infection.<br><br>Nurse #2, who worked with Resident #85 stated during an interview on 01/25/19 at 10:50 AM that the catheter was to be maintained below the resident's waist during transfers in order to prevent back flow into the bladder which could cause an infection. She stated she reeducated the nurse aide on 01/24/19.<br><br>The Director of Nursing stated on 01/25/19 at 12:41 PM that it was her expectation to ensure the catheter bag was kept below the bladder and that NA #1 told her it was at bladder level. She confirmed he had a history of urinary tract infections. | F 690 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services | F 755 | | 2/20/19 |

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| F 755 | Continued From page 19<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews the facility failed to keep an accurate account of controlled medications on the Individual Resident's Controlled Substance Record for 2 of 7 residents reviewed for unnecessary medications. (Resident #8 and Resident #7). | F 755 | -- Resident #8 was the only resident affected by the reported deficient practice. Immediate count of narcotics completed by the Director of Nursing.<br><br>-- All residents who receive controlled medications are identified as potentially | |

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| F 755 | Continued From page 20<br><br>The findings included:<br><br>1. An observation, interview and reconciliation of the narcotic medications on Cart A where Resident #8 resided was made on 01/24/19 at 2:41 PM with Nurse #1. The reconciliation revealed Resident #8 had 53 pills of Oxycodone Hydrochloride (HCl) 5 milligrams (mg) - ½ tablets to equal 2.5 mg and the Individual Resident's Controlled Substance Record indicated she had 52. Nurse #1 stated she had counted the narcotics at the beginning of her shift with the off going nurse. She added that to her knowledge the narcotic count was correct at that time. Nurse #1 stated she would alert her supervisor immediately of the discrepancy.<br><br>Review of the Controlled Drugs - Count Record for January 2019 for Cart A revealed on 01/24/19 at 7:00 AM Nurse #1 and the off going nurse had signed the sheet indicating the narcotic count was correct at that time.<br><br>Review of a Medication Error Report form dated 01/24/19 indicated on 01/24/19 Nurse #1 administered Resident #8 Oxycodone Hydrochloride 5 mg by mouth that was prescribed for Resident #7 instead of the Oxycodone Hydrochloride 5 mg - ½ tablet equaling 2.5 mg which was prescribed for Resident #8. The form indicated there was no adverse side effects noted to Resident #8 and the physician had been notified.<br><br>An interview was conducted with the Director of Nursing (DON) on 01/24/19 at 3:26 PM. The DON stated she had determined Nurse #1 had made a medication error by administering | F 755 | being affected by the reported deficient practice.<br><br>-- Education to be provided to all nurses on the six rights of medication administration. This education to be completed by 2/19/2019. New nurses will be educated upon hire. All nurses will receive education annually and as needed. Nurses will not be allowed to work after 2/19/2019 until this education is completed.<br>No systemic changes are necessary.<br><br>-- Audits to be completed twice weekly for two weeks, then weekly for four weeks, and then as needed. The audits will consist of observations of narcotic counts between shifts to ensure accurate reconciliation of narcotics. Audits to be completed by the Director of Nursing or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings for the next three months to ensure compliance is maintained. The next meeting is 2/19/2019. Overall completion date will be 3/29/19. | |

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| F 755 | Continued From page 21 | F 755 | | |

Resident #8 the dose of Oxycodone prescribed for Resident #7. The DON stated Nurse #1 did not recall making the error but stated she must have grabbed the wrong card of mediation. The cards are back to back in the medication cart and the DON stated she pulled the wrong card of medication. The DON stated she expected the nurses to administer the correct medications to the correct residents as prescribed by the MD.

An interview was conducted with Nurse #1 on 01/24/19 at 3:47 PM. Nurse #1 confirmed she had given Resident #8 the dose of Oxycodone prescribed for Resident #7. She stated she did recall medicating Resident #8 and stated she must have grabbed the wrong card of medication. Nurse #1 stated it was completely by mistake.

An interview was conducted with the DON on 01/25/18 at12:56 PM. The DON stated she expected the narcotic count to be accurate at all times and for the staff to count the narcotics at the beginning and ending of their shift and any time staff changed positions to a different cart.

2. An observation, interview and reconciliation of the narcotic medications on Cart A where Resident #7 resided was made on 01/24/19 at 2:41 PM with Nurse #1. The reconciliation revealed Resident #7 had 33 pills of Oxycodone Hydrochloride (HCl) 5 mg and the Individual Resident's Controlled Substance Record indicated he had 34. Nurse #1 stated she had counted the narcotics at the beginning of her shift with the off going nurse. She added that to her knowledge the narcotic count was correct at that time. Nurse #1 stated she would alert her supervisor immediately of the discrepancy.

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| F 755 | Continued From page 22 | F 755 | | |

Review of the Controlled Drugs - Count Record for January 2019 for Cart A revealed on 01/24/19 at 7:00 AM Nurse #1 and the off going nurse had signed the sheet indicating the narcotic count was correct at that time.

Review of a Medication Error Report form dated 01/24/19 indicated on 01/24/19 Nurse #1 administered Resident #8 Oxycodone Hydrochloride 5 mg by mouth that was prescribed for Resident #7 instead of the Oxycodone Hydrochloride 5 mg - ½ tablet equaling 2.5 mg which was prescribed for Resident #8. The form indicated there was no adverse side effects noted to Resident #8 and the physician had been notified.

An interview was conducted with the Director of Nursing (DON) on 01/24/19 at 3:26 PM. The DON stated she had determined Nurse #1 had made a medication error by administering Resident #8 the dose of Oxycodone prescribed for Resident #7. The DON stated Nurse #1 did not recall making the error but stated she must have grabbed the wrong card of mediation. The cards are back to back in the medication cart and the DON stated she pulled the wrong card of medication. The DON stated she expected the nurses to administer the correct medications to the correct residents as prescribed by the MD.

An interview was conducted with Nurse #1 on 01/24/19 at 3:47 PM. Nurse #1 confirmed she had given Resident #8 the dose of Oxycodone prescribed for Resident #7. She stated she did recall medicating Resident #8 and stated she must have grabbed the wrong card of medication. Nurse #1 stated it was completely by mistake.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 755 | Continued From page 23<br>An interview was conducted with the DON on 01/25/18 at12:56 PM. The DON stated she expected the narcotic count to be accurate at all times and for the staff to count the narcotics at the beginning and ending of their shift and any time staff changed positions to a different cart. | F 755 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, staff and Medical Doctor (MD) interviews the facility failed to administer the correct dosage of opioid medication to the correct resident as ordered for 1 of 7 residents sampled for unnecessary | F 757 | -- Resident #8 was the only resident affected by the reported deficient practice.<br><br>-- Every resident requiring medication administration by the nurses is identified | 2/20/19 |

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|---|---|---|---|
| | 345314 | A. BUILDING _____ B. WING _____ | C 01/25/2019 |

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| F 757 | Continued From page 24<br>medications (Resident #8). Resident #8 was administered Oxycodone Hydrochloride 5 milligrams (mg) tablet 1 tablet by mouth instead of Oxycodone Hydrochloride 5 mg tablet ½ tablet by mouth as she was prescribed.<br><br>The findings included:<br><br>Resident #8 was admitted to the facility 05/18/15 with diagnoses which included cerebral infarction, spastic hemiplegia and chronic pain.<br><br>Review of the most recent annual minimum data set (MDS) dated 10/17/18 indicated Resident #8 was cognitively intact for daily decision making. The MDS also indicated Resident #8 received 7 days of opioid medication during the assessment reference period.<br><br>Review of the physician order sheet dated 01/01/19 through 01/31/19 revealed Resident #8 was prescribed Oxycodone Hydrochloride 5 mg tablet - ½ tablet by mouth every 8 hours for pain. The medication was scheduled to be given at 6:00 AM, 2:00 PM and 10:00 PM.<br><br>An observation of the narcotic count on Cart A where resident #8 resided was made on 01/24/19 at 2:41 PM with Nurse #1 and revealed a discrepancy. The declining narcotic sheet indicated Resident #8 had 52 Oxycodone Hydrochloride pills remaining and there were 53 pills in the medication cart. Nurse #1 confirmed the discrepancy and stated she would notify her supervisor immediately.<br><br>An interview was conducted with Nurse #1 on 01/24/19 at 2:55 PM. Nurse #1 confirmed she had counted her medication cart at shift change | F 757 | as potentially being affected by the reported deficient practice.<br><br>-- Education to be provided to all nurses on the six rights of medication administration. This education to be completed by 2/19/2019. New nurses will be educated upon hire. All nurses will receive education annually and as needed. Nurses will not be allowed to work after 2/19/2019 until education is completed.<br><br>-- Audits to be completed twice weekly for two weeks, then weekly for four weeks, and then as needed. The audits will consist of observations of medication administration to ensure the use of the six rights, and accuracy with medication administration. Audits to be completed by the Director of Nursing or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings for the next three months to ensure compliance is maintained. The next meeting is 2/19/2019. Overall completion date will be 3/29/19. | |

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| F 757 | Continued From page 25 | F 757 | | |

that morning with the off going nurse and to her knowledge the narcotic count was correct. Nurse #1 stated there was a floor machine running behind she and the off going nurse which made it hard to hear but stated she thought the narcotic count was correct.

Review of a Medication Error Report form dated 01/24/19 indicated on 01/24/19 Nurse #1 administered Resident #8 Oxycodone Hydrochloride 5 mg by mouth that was prescribed for another resident instead of the Oxycodone Hydrochloride 5 mg - ½ tablet equaling 2.5 mg which was prescribed for Resident #8. The form indicated there was no adverse side effects noted and the physician had been notified.

An interview was conducted with the Director of Nursing (DON) on 01/24/19 at 3:26 PM. The DON stated she had determined Nurse #1 had made a medication error by administering Resident #8 another resident's Oxycodone. The DON stated Nurse #1 did not recall making the error but stated she must have grabbed the wrong card of mediation. The DON stated she expected the nurses to administer the correct medications to the correct residents as prescribed by the MD.

An interview was conducted with Nurse #1 on 01/24/19 at 3:47 PM. Nurse #1 confirmed she had given Resident #8 another resident's medication. She stated she did recall medicating Resident #8 and stated she must have grabbed the wrong card of medication. Nurse #1 stated it was completely by mistake.

An interview was conducted with Resident #8 on 01/25/19 at 12:55 PM. Resident #8 stated she

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| F 757 | Continued From page 26 | F 757 | | |

did not recall anyone telling her she had received the wrong dose of medication on 01/24/18 at 2:00 PM. Resident #8 stated she did not have any adverse effects from the medication yesterday.

An interview was conducted with the DON on 01/25/18 at12:56 PM. The DON stated she had failed to inform the resident she had received the wrong dose of medication on 01/24/19 at 2:00 PM. The DON stated she had counseled Nurse #1 and notified the MD, but it had not entered her mind to notify Resident #8.

An interview was conducted with the MD on 01/25/19 at 1:19 PM. The MD confirmed he had been notified that Resident #8 had received the wrong dose of medication. He stated he had told the staff to monitor Resident #8 for any adverse effects but stated he had not expected the resident to have any effects from the medication. The MD stated it was his expectation the nurses administer the correct medications to the correct resident as prescribed.

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| D 000 | Initial Comments<br><br>No deficiencies were cited as a result of this complaint investigation. Event ID #LPJ911. | D 000 | | |