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	345490	A. BUILDING _____ B. WING _____	02/07/2019

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E 000	Initial Comments An unannounced Recertification survey was conducted from 02/04/19 through 02/07/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SW3Q11.	E 000		
F 000	INITIAL COMMENTS A recerttification survey was conducted from 02/04/19 through 02/07. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the area of diagnosis on the Minimum Data Set assessment for 1 of 1 sampled residents reviewed for Preadmission Screening and Resident Review (PASRR) and the area of medications for 1 of 5 sampled residents reviewed for medications (Resident #39 and Resident #48). Findings included: 1. Resident #39 was admitted to the facility on 1/24/12 with diagnoses that included: dementia, hypertension and anxiety. Review of the record revealed resident did not	F 641	Ayden Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. Ayden Court Nursing and Rehabilitation's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Ayden Court and Rehabilitation reserves the right	3/5/19

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

Electronically Signed | 02/26/2019

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F 641	Continued From page 1 have a diagnosis of multiple sclerosis. Review of Resident #39's minimum data assessments (MDS) dated 6/13/18, 9/11/18, 12/6/18 and 1/8/19 inaccurately specified the resident had a diagnosis of multiple sclerosis in section I, question I5200. An interview with the MDS Coordinator on 2/6/19 at 4:30 PM stated Resident #39 had never been diagnosed with multiple sclerosis and question I5200 was coded inaccurately. During an interview on 2/6/19 at 4:41 PM the Director of Nursing stated it is her expectation that MDS assessments are coded accurately to reflect diagnoses. 2. Resident #48 was admitted to the facility on 5/13/15 with diagnoses that included: dementia, hypertension and anxiety. Review of the Medication Administration Record for January 2019 revealed Resident #48 received antipsychotic medication 1/9/19 and 1/10/19. Review of Resident #48's minimum data set assessment (MDS) dated 1/10/19 revealed the resident was assessed in section N, question N0450 as not receiving antipsychotics during the 7 day look back period of the assessment. During an interview on 2/7/19 at 11:45 AM the MDS Coordinator stated Resident #48 received antipsychotic medication during the look back period and question N0450 was coded incorrectly. An interview was conducted on 2/7/19 at 11:53	F 641	to refute and of the deficiencies on this Statement of Deficiencies through the Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F641 483.20(g) ACCURACY OF ASSESSMENTS On 2/7/2019 the Minimum Data Set (MDS) Coordinator completed a modification of MDS assessments dated 6/13/18, 9/11/18, 12/6/18 and 1/9/19 for resident #39 to reflect accurate coding of diagnosis by removing the diagnosis of Multiple Sclerosis. On 2/7/2019 the MDS Coordinator completed a modification of a MDS assessment dated 1/10/19 for resident #48 to reflect accurate coding of antipsychotic medication use. On 2/26/2019 the Nurse Supervisor and Staff Facilitator completed 100% audit of the most recent MDS assessment section “I” for all residents to include Resident #39 to ensure all MDS’s assessments completed are coded accurately for resident current diagnosis. The MDS will complete a modification to any assessment for any identified area of concern during the audit with the oversight from the Director of Nursing (DON). No additional concerns identified. Audit was completed on 2/26/2019. On 2/26/2019 the Nurse Supervisor and Staff Facilitator completed 100% audit of the most recent MDS assessment section “N” for all residents to include Resident #48 to ensure all MDS’s assessments completed are coded accurately to include	

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F 641	Continued From page 2 AM with the Director of Nursing who stated it is her expectation that MDS assessments are coded accurately to reflect medications received.	F 641	all residents that are receiving antipsychotics. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversight from the DON. The MDS Coordinator will complete a modification to any assessment for any identified area of concern during the audit with the oversight from the DON. No additional concerns identified. Audit was completed on 2/26/2019. On 2/12/2019 a 100% in-service on MDS Assessments and Coding was completed by the DON with all MDS nurses and MDS Coordinator, regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to include resident diagnosis or any resident on antipsychotic medication. All newly hired MDS Coordinator or MDS nurses will be in-serviced in regards to MDS Assessments and Coding during orientation by the Staff Facilitator to include proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual. 25% audit of complete MDS assessments, to include assessments for resident #39 and resident #48 utilizing the MDS Accuracy QA Tool will be completed by the Nurse Supervisor and Staff Facilitator weekly x 8 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include residents diagnosis and residents receiving antipsychotic medications. All identified areas of concern will be addressed	

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F 641	Continued From page 3	F 641	immediately during the audit by the DON to include re-training of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review and initial the MDS Accuracy QA Tool weekly x 8 weeks and then monthly x 1 month to ensure any areas of concern have been addressed. The DON will forward the results of MDS Accuracy Tool and the Diagnosis Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the MDS Accuracy Tool and the Diagnosis Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and /or frequency of monitoring. The Administrator and Direct of Nursing will be responsible for the implementation of corrective action to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and	F 689	Past noncompliance: no plan of	2/26/19

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F 689	Continued From page 4 physician interviews, the facility failed to place bilateral bed rails on the bed which were utilized by the resident for bed mobility and during the provision of care the resident fell from the bed for 1 of 2 sampled residents reviewed for accidents (Resident #11). Resident #11 sustained a fractured right hip as a result of his fall. The findings included: Resident #11 was admitted to the facility on 8/15/14. His diagnosis included stroke, bilateral above the knee amputations and end stage renal disease. A review of Resident #11's Care Plan revealed a focus dated 6/29/18 which read "Use of bed rails for increasing or maintaining current bed mobility and transfer ability." A medical record review revealed an 8/13/18 Quality Assurance Note which stated Resident #11 requested "to have bilateral side rails to aid in bed mobility and for ADL (activities of daily living) assistance with staff." The note stated a bed rail evaluation was completed and bed rails were installed. The resident was educated on the risk and benefits of the rails and how to use them. The note also stated the care plan and care guide were up dated. A review of the Minimum Data Set (MDS) dated 10/5/18, a quarterly MDS revealed Resident #11 was cognitively intact (BIMS 15). He had no behaviors. He required extensive assistance of 1 staff for bed mobility and he was totally dependent of 1 staff for bathing. He had limited range of motion on both sides of the lower extremities. He was always incontinent of bowel	F 689	correction required.	

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and bladder. He had no falls.

A review of the nursing progress note dated 10/30/18 written by Nurse #4 revealed at approximately 11:15 AM Resident #11 fell out of bed during morning care. The note stated the assessment showed no apparent injuries and the resident denied pain. He was transferred to the wheelchair. The note also stated he continued to be in good spirits at the end of the shift.

A record review of the incident report dated 10/30/18 revealed at approximately 11:15 AM Nurse #4 was notified by the Director of Nursing that the resident (Resident #11) was on the floor. The report note read that several nurses and the administrator assisted the resident via lift into his wheelchair. The report stated the resident was assessed prior to transfer by Staff Development Coordinator (SDC) #1. The report also said the resident stated his hand slipped while being on his side during care. The report stated no injuries were observed at that time. Additional review of the report revealed the witnesses were Nursing Assistant (NA) #1, Nurse #4, Nurse Supervisor #1, Administrator #1, Nurse #5 and Staff Development Coordinator (SDC) #1.

During an interview on 2/5/19 at 11:00 am Resident #11 stated he fell out of his bed while he received a bath because there were no rails for him to hold onto. He said his previous bed broke so the facility replaced his bed but did not put the bed rails back on it. He reported the fall happened a few months ago.

During an additional interview with Resident #11 on 2/7/19 at 12:23 pm he stated when he returned for hemodialysis on Monday (10/29/18)

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he had a brand new bed with no side rails. He stated he remembered SDC #1 and Administrator #1 coming into his room looking at the bed and talking about getting bed rails for the bed. He said he knew he needed the bed rails but on the day he fell he wanted to get out of bed and did not want to wait for the rails so he told NA #1 to give him his bath now and not to wait for the rails to be installed.

During an interview with the Nursing Assistant (NA) #1 on 2/5/19 at 2:50 PM she stated in October 2018 Resident #11 told her his bed broke over the weekend and his new bed did not have bed rails. NA #1 said Resident #11 needed bed rails to assist him during care. She said he used his right arm to grab the rail for support for rolling over during his bath and when she was providing incontinent care. She stated he had a fall off of the bed on Tuesday (10/30/18) when she was giving him a bath. She stated he was holding onto the side of the bed with his right hand with his back facing her. NA #1 reported she was holding him with her left hand and using her right hand to clean his bottom when he rolled off of the left side of the bed. She stated she tried to stop him but she had cream on her right hand and when she grabbed the lower part of his back he continued to roll and fell off of the bed on the side opposite of where she was standing. She said she then ran to the hall to get a nurse. She stated she did not remember which nurse came in first. She said the "code green" was called and more staff arrived. The NA added the nurse checked him and during this he was laughing. She said she and the nurse gently rolled Resident #11 over and put a brief on him. She said he was still laughing and said for her to put his clothes on him while he was on the floor. NA #1 said they

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used a lift pad and the lift to put him in his wheelchair. She added 2 days later Resident #11 complained of pain and they found out his hip was broken.
During additional interview with NA #1 on 2/7/19 at 12:00 PM she stated on 10/30/18 prior to Resident #11's fall from the bed she did lower his bed when she provided his care because she could not reach over him if the bed was as high as he kept it. She stated she lowered Resident #11's bed to about her hip level. A measurement was taken and the distance from NA #11's hip to the floor was 37.5 inches.

During an interview on 2/7/19 at 10:24 AM Nurse Supervisor #1 stated on the day of the fall she heard NA #1 say "Code Green" so she went immediately into Resident #11's room and he was lying face down on the floor between the left side of the bed and the wall. He was not touching the bed or the wall. She stated the bed was approximately 4 feet high. She stated she and Nurse #5 asked him if he was in pain and he said no. Then she moved his joints and completed the full body assessment and no concerns were identified. He had his same normal demeanor.

During an interview on 2/7/19 at 11:01 AM the Interim Maintenance Director reported she replaced the bed control for Resident #11 which fixed the bed for a few days but then it stopped working again so she put a new bed in his room. She said she began putting new beds together on 10/29/18 so that may have been when she put the bed into Resident #11's room. She stated she was not the person who put rails on beds but SDC #1 was the person who knew how to put bed rails on beds.

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During an interview with SDC #1 on 2/7/19 at 11:10 AM she stated she was the person who would be informed of any bed moves or changes because she was responsible for ensuring the interventions for the resident were in place whenever a change was made. She stated she was not informed of the new bed for Resident #11 until Tuesday (10/30/18) morning so she looked at his bed. She tried to find rails in her in house supply but there were none. She said she noticed there were no rail holders because it was a new bed so she asked Administrator #1 to help her find rails and figure out how to put them on. SDC #1 said she and Administrator #1 went together to look at Resident #11 ' s bed. She stated while she and Administrator #1 were in the room, NA #1 was present and giving a bath to the roommate for Resident #11. SDC#1 stated she told NA #1 that they would return with rails for Resident #11's bed. She stated Administrator #1 found a bed manual and that was when they determined they needed additional parts so they went outside to the barn to look for the proper rails and rail clamps.

On 02/07/19 at 3:29 PM Nurse #5 was interviewed via telephone. She stated Resident #11 was alert and oriented, was verbal about his needs and let his needs be known. She reported he had a fall and she heard code green called. She added when she arrived at his room he was on the floor on his back with a pillow under his head. He was talking and carrying on. He was embarrassed he had fallen off of the bed. She added that she checked him and he had no pain, he was just embarrassed. She said she was told he fell off the bed but she was not present when it happened. Nurse #5 said Resident #11 had rails on his bed prior to that day but she didn't know

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why he did not have bed rails that day.

Administrator #1 was not available for interview during the survey.

Additional record review revealed a note written on 10/30/18 at 10:00 pm by Nurse #7 which stated Resident #11 had increased pain but no other symptoms based on the physical assessment. He was given a pain medication and the physician was informed. The physician ordered an x-ray to rule out fractures.

A revive of the results of the x-ray report for Resident #11 dated 11/1/19 revealed no fracture.

A nurse ' s note written on 11/1/18 read Resident #11 had a decrease in his oxygen saturation level at 4:00 PM but he refused to wear oxygen or to go to the hospital. His responsible party was notified and she convinced the resident to wear oxygen. Then at 10:00 PM he developed a low grade temperature so he received acetaminophen. The physician was informed and the responsible party was informed. The nursing notes revealed at 10:36 PM the responsible party requested the resident be sent to the hospital so the physician was notified, the orders were received and the resident was sent to the emergency room for an evaluation at 10:52 PM.

A review of the hospital discharge summary for Resident #11 dated 11/7/18 revealed a right femoral neck fracture was identified on 11/1/18 and he had surgical repair of the right hip on 11/3/18 then was discharged back to the facility on 11/7/18.

During an interview on 2/7/19 at 4:00 PM

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Physician #1 stated Resident #11 fell and broke his hip. He said he did not remember the details of the fall. He stated the resident had not had a decline in his functional abilities or his mental status because of the fall.

During an interview with the Director of Nursing on 2/7/19 at 2:30 PM she stated she had a plan of correction for Resident #11's fall. She stated the investigation revealed he did not have side rails and the NA did not properly align the resident in the bed while providing care when Resident #11 fell from the bed on 10/30/18.

On 2/7/19 at 8:29 PM the facility provided the plan of correction for tag F689 as follows:
F 689

The process that lead to deficiency Resident # 11 is alert and oriented and has diagnoses of double amputee, end stage renal with Hemodialysis. Resident # 11 is able to safely use the bed rails for positioning. On 10/29/2018 resident # 11's bed was changed to a bed without bed rails. On 10/30/2018 Nursing Assistant was turning resident to wash back and resident # 11's hand slipped from mattress causing resident #11 to fall off of the bed. Registered Nurse (RN) supervisor assessed resident # 11 and no injuries noted at this time. Attending physician and Resident Representative (RR) notified of resident # 11's fall. Later in the shift resident # 11 complained of pain in the right upper leg. Assigned hall nurse assessed resident # 11 and no edema or deformity noted. Resident # 11 was able to move right upper leg. Assigned hall nurse called attending physician and orders received for an X-ray of bilateral upper legs. X-ray completed with no fracture noted at this time. On 11/1/2018 resident # 11 was sent to the Emergency Room

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for fever and found to have a right femoral fracture. The process that lead to the deficiency was that the NA failed to properly position resident # 11 in bed and bed rails absent from the bed.

The procedure to implement a plan of correction for specific deficiency
On 10/30/2018 at approximately 12:00pm resident # 11's bed rails were placed on bed by the Administrator and the Staff Facilitator (SF). The NA was educated by the Director of Nursing (DON) and SF in regards to proper positioning during care and ensuring all interventions to include bed rails were in place, once education provided NA completed a return demonstration of correct positioning. A 100% audit was completed on 11/3/2018 by the SF of all residents' care guides to ensure that if bed rails are need that bed rails were on the bed. There were 16 areas of concerns noted. All areas of concerns were corrected during the audit by the DON and SF. On 11/8/2018 a 100 % audit was initiated by the DON and the SF on turning and repositioning during care utilizing a Turning and Repositioning Care audit tool. Audits were completed on 11/12/2018. No negative findings noted during the audit. On 11/2/2018 a 100% audit was initiated by the DON and SF with all licensed nurse and NA's in regards to proper positioning during care and ensuring all interventions, to include bed rails, are in place. In-services completed on 11/12/2018. All newly hired licensed nurse and NA's will be in-serviced by the SF during orientation in regards to proper positioning during care and ensuring all interventions to include bed rails are in place.

The procedure for monitoring the plan of correction

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F 689	Continued From page 12	F 689		

All resident's with a bed change or a room change were audited by the SF to ensure all interventions to include bed rails were in place utilizing a Location Bed change tool 5 X week X 2 weeks, then 2 X a week X 1 week, then 1 X a week for a week. The DON reviewed and initialed the Location Bed change tool weekly for 4 weeks to ensure all areas of concerns were addressed.

The title of person responsible for implementing the plan of correction

The Administrator and DON were responsible for the implementation of corrective actions to include all 100% audits, in-service and monitoring related to the plan of correction.

The DON presented the initial findings of the Location Bed Change tool and Turning and Repositioning care audit tool to the Executive Quality Assurance (QA) Committee on 11/3/2018. The DON presented the findings of the Location Bed change tools and turning and repositioning to the Executive QA Committee on 11/29/2018 and 12/14/2018.

Date corrective action completion
Final Compliance date was 11/12/2018.

Observations of Resident#11's bed revealed bed rails were in place upon initial tour on 2/4/18 and have been in place throughout the survey.

During the phone interview with Nurse #5 on 2/7/19 3:29 PM she stated, "We received in-service education on positioning the residents in the bed when turning them and to roll them toward self not away from person giving care. He was a top heavy person He was the same after

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	345490	A. BUILDING _____ B. WING _____	02/07/2019

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F 689	Continued From page 13 he returned from the hospital. He was able to do the same things and had not loss of function." The plan of correction was verified through review of the verification of education provided on both resident alignment in bed and use of bed rails, a review of the audits and monitoring documentation and the quality assurance meeting minutes. Staff interviews verified the education provided. A review of care plans for bed rails and observations of the rails in place as care planed was also completed. The facility's date of compliance of 11/12/18 was verified.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (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 (iii) A resident who is incontinent of bladder	F 690		3/5/19

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F 690	Continued From page 14 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews and record review the facility failed to keep a urinary catheter bag from coming in contact with the floor for 1 (Resident #1) of 2 residents reviewed for catheter care. The findings included: Resident #1 was admitted to the facility on 6/30/17. His diagnoses included seizure disorder, neurogenic bladder and aphasia. The quarterly Minimum Data Set (MDS) dated 11/2/18 revealed Resident #1 was severely cognitively impaired and he required total assistance for all activities of daily living. Resident #1 had an indwelling urinary catheter and was incontinent of bowel. A review of the care plan revised on 1/21/19 revealed the care plan addressed the altered pattern of urinary elimination with an indwelling catheter (suprapubic) related to a diagnosis of neurogenic bladder. The interventions included empty the drainage bag each shift. The care plan also addressed the problematic manner in which	F 690	F690 483.25 (1)-(3) Bowel/Bladder Incontinence, Catheter, UTI On 2/6/2019 resident #1 catheter bag was repositioned by Staff Facilitator, and Nurse Consultant, so that catheter bad was not positioned on or touching the floor. On 2/11/2019 a 100% audit of all residents to include resident #1 with catheter bags was completed by the Staff Facilitator to ensure no catheter bag was positioned on or touching the floor. All areas of concern were immediately corrected during the audit by the Staff Facilitator to include repositioning catheter bag so it was not positioned on or touching the floor and education of staff. There were no identified areas of concern. On 2/11/2019 100% in-service was initiated by the Staff Facilitator with all nurses and nursing assistant (NA) to include Nurse #2 and NA #1 in regards to Positioning of Catheter Bags to include Foley catheter bags are not to be positioned on or touching the floor. If a resident's bed must be in the lowest	

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F 690	Continued From page 15	F 690		

he acts characterized by "inappropriate behavior (will put things in his mouth if he can reach them.)"

An observation on 2/4/19 at 9:30 am revealed Resident #1 was in his bed which was in the lowest position. The covered urinary catheter bag was observed with the bottom ¼ of the bag touching the floor.
An observation on 2/5/19 at 10:13 am revealed Resident #1 was in bed which was in the lowest position. The fall mattress was beside the bed and pushed up under the side of the bed. The urinary catheter bag could be seen pushed under the bed by the mattress and was touching the floor.

On 2/5/19 at 2:33 pm Nursing Assistant (NA) #1 stated she frequently worked with Resident #1 and she was familiar with his urinary catheter bag. She stated she emptied it daily on her 7:00 am to 3:00 pm shift usually when she gave him a bath in the mornings prior to getting him up to his wheel chair.

On 2/5/19 at 3:53 pm Resident #1 was in his bed. His urinary catheter bag was observed laying on the fall mat which was under the fall mattress.

On 2/6/19 at 9:15 am Resident #1 was observed in his bed. His urinary catheter bag was observed touching the floor.

On 2/6/19 at 9:16 am NA #1 was asked to observe the urinary catheter bag. During the observation she stated the urinary catheter bag was touching the floor because the bed had to be in the lowest positon due to the resident ' s risk for falls. She added he did have a fall mat and fall

position possible then the catheter bag should be placed inside a black catheter sleeve to decrease the risk of infection. Attach the catheter bag to the foot of the bed and elevate the foot of the bed to a height so that the catheter bag is not positioned on or touching the floor. The in-service will be completed by 3/4/2019. All newly hired nurses and NAs will be in-serviced in regards to Positioning of Catheter Bags during orientation by the Staff Facilitator.
100% audit of all residents with catheter bags will be completed by the Treatment Nurse to include resident #1 utilizing the Catheter Bag Audit Tool 5 times a week x 1 week, 3 times a week x 1 week, 2 times a week x 1 week, then weekly x 1 week to ensure catheter bags are not positioned on or touching the floor. The Treatment Nurse will immediately correct during audit any identified areas of concern to include repositioning of catheter bags so it is not positioned on or touching the floor and/or re-training of staff. The DON will review and initial the Catheter Bag Audit Tool weekly x 4 weeks to ensure all areas of concern have been addressed.
The DON will forward the results of Catheter Bag Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Catheter Bag Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.
The Administrator and Director of Nursing

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F 690	Continued From page 16 mattress beside the bed due to his high risk for falls. She said she could not prevent the bag from touching the floor when the bed was in the lowest position. On 2/6/19 at 9:30 am Nurse #2 observed the urinary catheter bag and stated it was touching the floor because the bed had to be in the lowest position due to the resident's high risk for falls. During the interview on 2/6/19 at 9:30 am in the resident's room with Nurse #2, the Director of Nursing (DON) and the facility consultant nurse entered the room. The DON stated she was not sure how to handle the urinary catheter bag touching the floor, the resident's mobility and his need to have his bed low due to his mobility and falls plus not using bed side rails. The facility consultant stated it was difficult to balance the need to keep the urinary catheter bag out of the resident ' s reach, keep the bed low due to his risk for falls and keep the urinary catheter bag from touching the floor.	F 690	will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, pharmacist interviews and record review the facility failed to maintain a medication administration error rate of less than 5% when a nurse failed to ensure a Colace capsule was	F 759	F759 483.45 (f)(1) Free of Medication Error Rate 5 Percentage or More On 2/5/2019 resident #18 was assessed by nursing staff and the physician was notified by the DON of the medication	3/5/19

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F 759	Continued From page 17 swallowed by a resident, failed to administer Aspirin as ordered by the physician, and failed to administer a medication with food as ordered by the physician. This resulted in an error rate of 12% for 3 of 25 opportunities observed for 2 of 4 residents during medication pass. (Resident #18 and Resident #49) Findings included: 1. Resident #18 was admitted to the facility on 3/14/18. Her active diagnoses included hypertension, dysphagia, and chronic atrial fibrillation. Review of Resident #18's minimum data set assessment dated 11/28/18 revealed the resident was assessed as severely cognitively impaired. Review of Resident #18's orders for February 2019 revealed she was ordered Colace 100 milligrams by mouth twice daily and Aspirin 81 milligrams enteric coated ("enteric coated" Aspirin means the Aspirin does not dissolve until it is in the small intestines to protect the stomach) by mouth daily. During observation on 2/5/19 at 8:08 AM Nurse #1 was observed providing medications to Resident #18. The resident was observed to receive a chewable Aspirin 81 milligrams crushed in pudding as well as a whole Colace 100 milligrams capsule. After the medications were placed in the resident's mouth and water was provided to Resident #18, the nurse turned to the sink in the room and washed her hands with her back to the resident. The Colace 100 milligram capsule provided to the resident was observed to fall out of Resident #18's mouth and under her	F 759	error to include administering/crushing aspirin ordered as enteric coated and resident failing to take Colace as ordered with no new physician orders. A medication error report was completed by the DON. On 2/6/2019 resident #49 was assessed by nursing staff and the physician was notified by the DON of the medication error to include administering medication without food that was ordered as “take with food” with no new physician orders. A medication error report was completed by the DON. On 2/19/2019 100% Medication Pass Audit was initiated by Staff Facilitator, Supervisor, Treatment Nurse and DON with all nurses to include nurse #1 and nurse #2 to ensure all medications were given per physician order to include to give with food or in the enteric coated form and that the nurse verified the medications were swallowed when given. The Staff facilitator, Supervisor, and Treatment Nurse will immediately address all areas of concern during the audit to include assessment of resident when indicated, notification of physician for any identified concerns, obtaining new orders when appropriate and education of staff. The audit will be completed by 3/5/2019. On 2/15/2019 100% in-service was initiated with all nurses to include nurse #1 and nurse #2 by the Staff Facilitator in regards to Medication Administration to include the six rights of a medication pass, three checks of a medication pass, identifying the right resident, medication carts, infection control, documentation	

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F 759	Continued From page 18 clothing protector. The nurse exited the room and documented Colace 100 milligrams as having been given. During an interview on 2/5/19 at 8:30 AM Nurse #1 stated Resident #18 had received her Colace in the pudding and she had already documented it on the medication administration record. Upon observing Resident #18, with the surveyor, the Colace capsule was found under the resident's clothing protector. The nurse stated she was not aware Resident #18 had not swallowed the medication and was a medication error. She concluded she would correct the mistake at that time. During an interview on 2/5/19 at 9:31 AM Nurse #1 stated she gave chewable Aspirin 81 milligrams instead of enteric coated Aspirin 81 milligrams because she didn't see the order correctly and knew Resident #18 received most of her medications crushed. She also stated she had documented the enteric coated aspirin as given. She concluded this was a medication error as well. During an interview on 2/5/19 at 9:55 AM the Director of Nursing stated it was her expectation Nurse #1 ensured Resident #18 had completed taking all of her medications before turning her back to Resident #18. The Director of Nursing stated she had given Resident #18 the Colace capsule multiple times and Resident #18 could swallow a capsule. The Director of Nursing further stated Resident #18 was also ordered enteric coated Aspirin 81 milligrams which should not be crushed. She stated the nurse should not have changed the type of Aspirin from what the physician ordered for Resident #18 to crush the	F 759	and medication administration to include but not limited to following physician's order and reading Medication Administration Record (MAR) for special instructions such as do not crush or take with food. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Medication Administration. In-service will be completed by 3/5/2019. 25% of all nurses to include nurse #1 and nurse #2 will complete a Medication Pass Audit utilizing the Medication Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all medications were given per physician's order to include to give with food or in the enteric coated form and that the nurse verified the medications were swallowed when given. The Staff Facilitator, Supervisor and Treatment Nurse will immediately address all areas of concern during the audit to include assessment of resident when indicated, notification of physician for any identified concerns, obtaining new orders when appropriate and re-training of staff. The DON will review the Medication Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The DON will forward the results of Medication Pass Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Medication Pass Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further	

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medication. She concluded both instances were medication errors.

During an interview on 2/5/19 at 11:00 AM the Facility Pharmacist Consultant stated Nurse #1 should not have changed the Aspirin from enteric coated to chewable Aspirin and crushed it. He concluded she should have given the medication as ordered and it was a medication error.

2. Resident #49 was admitted to the facility on 8/2/16. His active diagnoses included diabetes mellitus.

Review of Resident #49's minimum data set assessment dated 1/14/19 revealed the resident was assessed as cognitively intact.

Review of the meal schedule for the facility revealed Resident #49's hall received their lunch at 12:40 PM and dinner at 5:45 PM.

Review of Resident #49's physician orders revealed he was ordered Glucophage 500 milligrams extended release by mouth twice daily to be taken with food.

During observation on 2/6/19 at 3:25 PM Nurse #2 was observed to administer Glucophage 500 milligrams extended release to Resident #49.

During an interview on 2/6/19 at 3:47 PM Resident #49 stated he last ate any food at 1 PM. He further stated dinner usually did not come on the hall until later after 5 PM.

During an interview on 2/6/19 at 3:51 PM the Facility Pharmacy Consultant stated the Glucophage 500 milligrams extend release

and/or frequency of monitoring.
The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.

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F 759	Continued From page 20 should have been given with the initiation of the meal or within thirty minutes of completion of the meal and it was a medication error to give the Glucophage at 3:25 PM when the resident had eaten at 1 PM and would not eat again until after 5 PM. During an interview on 2/6/19 at 4:01 PM Nurse #2 stated she thought Resident #49 had eaten when his wife visited which was about 3:10 PM. She concluded she should have confirmed with him the last time he ate and that it was a medication error. During an interview on 2/6/19 at 4:04 PM the Director of Nursing stated it was her expectation medications be given as ordered. She further stated Glucophage should be given with meals and Nurse #2 should have clarified if Resident #49 had eaten just prior to the medication being given. She concluded it was a medication error.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		3/5/19

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F 812	Continued From page 21 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired ice cream and yogurt in 2 of 3 nourishment room refrigerators observed. Findings included: 1. During observation on 2/7/19 at 10:20 AM of the station 3 nourishment room refrigerator, a cup of ice cream provided for the residents by dietary was observed to have a best by date of 5/3/18. During an interview on 2/7/19 at 10:51 AM the Dietary Manager stated the ice cream should have been removed by the dietary staff and did not know why it had not been removed. During an interview on 2/7/19 at 10:55 AM Dietary Assistant #1 stated she only counted the ice cream and did not flip them over to see the best by dates, so she did not know it was past the best by date. 2. During observation on 2/7/19 at 10:24 AM of the station 1 nourishment room refrigerator, a yogurt cup not provided by dietary was observed with the expiration date of 8/19/18. During an interview on 2/7/19 at 10:51 AM the Dietary Manager stated she and her staff were not responsible for anything not placed in the refrigerator by dietary and would not check the	F 812	F812 483.60 (i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary On 2/11/19 100% audit of all nourishment refrigerators to include nourishment room station three (3) and nourishment room station one (1) was completed by the Staff Facilitator to ensure there were no expired items or items that were not dated. All expired items were discarded by the Staff Facilitator during the audit. On 2/12/19 100% in-service was initiated by the Staff Facilitator with all nurses, dietary staff and receptionists in regards to Nourishment Refrigerators to include nourishment room refrigerators must be checked each shift by nurses to ensure expired food/drinks are discarded. Dietary staff are responsible for ensuring all items placed in the nourishment refrigerator supplied by dietary is within date and should monitor all current dietary supplies in the nourishment refrigerator to ensure expired items are discarded promptly. The Receptionists are responsible for checking nourishment room refrigerators twice a day to ensure temperatures are within acceptable range and that all expired items are discarded promptly. The receptionist will notify the nurse and/or Director of Nursing immediately of any concerns related to temperatures ranges. In-service will be completed by 3/5/2019.	

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F 812	Continued From page 22 dates and nursing checked those items. During an interview on 2/7/19 at 11:01 AM Nurse #3 stated the receptionists checked the dates for resident items in the nourishment refrigerator. During an interview on 2/7/19 at 11:04 AM Receptionist #1 stated she only checked nourishment refrigerator temperatures and not expiration dates. During an interview on 2/7/19 at 11:05 AM Receptionist #2 stated she only checked nourishment refrigerator temperatures and not expiration dates. During an interview on 2/7/19 at 11:05 AM the Nurse Supervisor stated dietary was responsible for checking expiration dates in the nourishment rooms. During an interview on 2/7/19 at 11:07 AM the Facility Consultant stated she thought dietary would check nourishment refrigerators for expiration dates but was not sure who was responsible. During an interview on 2/7/19 at 11:10 AM Director of Nursing stated she thought dietary would check the nourishment room expiration dates. She concluded maybe nursing staff checked resident specific items and it was her expectation whoever was responsible for the nourishment refrigerators would have discarded the yogurt. During an interview on 2/7/19 at 12:06 PM the Administrator #2 stated he did not know which department was responsible for checking	F 812	All newly hired nurses, dietary staff and receptionists will in-serviced during orientation by the Staff Facilitator in regards to Nourishment Refrigerators. 100% audit of all nourishment room refrigerators to include nourishment room station 3 and nourishment room station 1 will be completed by the Staff Facilitator or Nurse Supervisor 5 times a week x 1 week, 3 times a week x 1 week, 2 times a week x 1 week and weekly x 1 week utilizing the Nourishment Room Audit Tool to ensure there are no expired items in the refrigerator and/or expired items are discarded promptly. All areas of concern will be immediately addressed by the Staff Facilitator and Nurse Supervisor to include removal of expired items and re-training of staff. The DON will review and initial the Nourishment Room Audit Tool weekly x 4 weeks to ensure all concerns were addressed appropriately. The DON will forward the results of Nourishment Room Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Nourishment Room Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 23 expiration dates in the nourishment rooms, but now that the concern was identified they would clarify who was responsible.	F 812		