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

Printed: 11/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055531	A. BUILDING _____ B. WING _____	11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYALWOOD CARE CENTER	22520 MAPLE AVENUE TORRANCE, CA 90505

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F 000	INITIAL COMMENTS The following reflects the findings of The Department of Public Health during a Recertification survey and Entity Self-Reported (ERI) investigations. ERI Number: CA00558669 - Unsubstantiated. ERI Number: CA00559825 - Unsubstantiated. Representing The Department of Public Health: Surveyor ID: 19005 - RN, HFEN Surveyor ID: 35728 - RN, HFEN Surveyor ID: 36333 - RN, HFEN Resident Population: 71 Resident Sample Size: 15 Randomly Selected Residens: 6 Highest Severity and Scope: E	F 000	**This document will serve as a credible allegation of our intent to correct the deficient practice identified. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the truth of the facts alleged of conclusion set forth on the statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code section 1280 and 42 C.F.R 405.1907.**	
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 157	**F157 Notification of Changes** **Immediate Corrective Action:** On 11/2/17, the licensed nurse notified the Attending Physician of Resident 10's missed Digoxin and Creatinine lab draw. An order for Digoxin and Creatinine lab draw was obtained and completed on 11/2/17. The results of the lab was reported to the Attending Physician on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 12/4/17

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

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F 157	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure diagnostic results for serum levels (the blood level of the medication in the blood) for Digoxin (can treat heart failure and heart rhythm problems) and Creatinine (a blood test that measures kidney function) lab values were reported to the attending physician timely and the physician was notified of the lab results for one of 15 sampled selected residents (10).	F 157	11/2/17. On 11/3/17, Digoxin was ordered by the physician to be discontinued. **Potential Residents that can be affected:** The Director of Nursing and the Health Information Manager (HIM) will conduct an audit of Digoxin and Creatinine lab orders in the past 30 days to assure that lab orders were carried out timely and results reported to the physician. Issues identified during the audit will be immediately reported to the Director of Nursing and Attending Physician for follow up. This audit will be completed by12/7/2017. **System Change:** The DON initiated in-services with the Licensed Nurses on the Policy and Procedures on Diagnostic Testing with	

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F 157	Continued From page 2 The deficient practice created the potential for care and services. Findings: According to the admission records Resident 10 was admitted to the facility on 8/18/2017, with diagnoses that included cerebral infarction (blockage in the blood vessels supplying blood to the brain), muscle weakness, difficulty in walking, heart failure (inability to pump an adequate supply of blood), hemiplegia (complete paralysis of half of the body) and hemiparesis (weakness of one entire side of the body). The Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 8/25/2017, indicated Resident 10's speech was clear, the resident was able to make himself understood and understood others. The resident's cognitive skills for daily decision making was intact. The resident required limited assistance from staff with transferring, bed mobility and eating. A review of the Pharmacy Consultant report dated 09/06/2017 indicated the recommendations indicated Resident 10 should receive a Digoxin level because there was no serum concentration levels in the resident's record. The physician's response indicated there was an acceptance of the recommendation from the pharmacy consultant. The report also indicated the resident did not have an assessment of the renal function. The physician's response was to accept the	F 157	emphasis on assuring lab orders are completed as ordered and results are reported timely upon receipt to the attending physician. Education will be completed by 12/7/17. The licensed nurses at the beginning of shift will review the diagnostic lab book for labs that were drawn and will ensure that lab results are followed up and reported to the attending physician upon receipt. Concerns identified will be reported to the RN Supervisors for follow up. **Monitoring:** During morning clinical meeting, lab results from previous day and lab results that were drawn for the day will be reviewed by the Unit manager/RN Supervisor to ensure that labs were drawn as ordered and the Attending Physician was notified of the	

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F 157	Continued From page 3 pharmacy consultant's recommendation. A review of Resident 10's physician order, dated 09/20/2017 indicated a Digoxin and Creatinine level to be obtained in the morning (09/21/2017) and every six months. A review of the Pharmacy Consultant report dated 10/04/2017, indicated Resident 10 had orders for labs to be drawn for Digoxin and Creatinine. However, the lab results was not available in the resident's record. During a record review on 11/1/2017 at 10 a.m., in the presence of the Registered Nurse Unit Manager Station A (RN 2) about Resident 10's missed Digoxin and Creatinine blood serum levels, stated the physician's orders for the Digoxin and Creatinine labs should have been followed and drawn on 09/20/2017. A review of the clinical records with RN 2 on 11/1/2017, indicated there was no documentation the Digoxin and Creatinine labs were drawn for Resident 10. There was no indication to show the physician had been notified regarding the lab results that had been missed. A review of the 11/1/2017 recapitulated physician's orders indicated serum labs for the Creatinine level and Digoxin level one time a day, every six months via the telephone to start on the 21st day. The order indicated to give Aspirin 81 milligram (mg [a stroke prophylaxis]) and Digoxin Tablet 125 microgram (treats congestive heart	F 157	results when received. Identified issues will be reported to the Director of Nursing and Attending Physician immediately. The Director of Nursing will bring the results of the laboratory orders audit to the Quality Assurance and Performance Improvement Committee for review and recommendation monthly for three months then quarterly thereafter until substantial compliance has been achieved. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed. **Completion Date:** December 7, 2017	

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F 157	Continued From page 4 failure and heart rhythm problems) give one tablet once time a day, Clonidine HCL tablet 0.3 mg three times a day and Lisinopril Tablet 20 mg twice a day (treats high blood pressure). A review of the Diagnostic Lab results with RN 2 indicated Resident 10's lab results were faxed to the facility on 11/2/2017. The Creatinine and Digoxin Serum were collected on 9/21/2017. The Creatinine Serum l.06 milligram/deciliter (mg/dl) and the reference range 0.70 - 1.30. The Digoxin Therapeutic Levels as followed: For Congestive heart failure 0.8 - 1.5 nano grams per milliliter (ng/ml). For Arrhythmia (a heart rhythm problem the heart beats too fast or too slow or irregularly) 1.5 - 2. 0 ng/ml. The Critical Level greater than 2.5 ng/ml. The Digoxin Serum lab result was 0.2 ng/ml and the reference range 0.8 - 2.0 ng/ml. During an interview on 11/2/2017 at 10:30 a.m., with RN 2 she stated Resident 10's serum Creatinine was within the reference range and the Digoxin serum level was 0.2 which was below the reference range of 0.8 0 2.0. According to the facility's policy and procedure titled, 'Diagnostic Test', revised 11/29/2016 indicated Diagnostic Tests including laboratory, radiologic, pulmonary, and waived testing (e.g. finger stick glucose monitoring, hem occult testing) will be performed as ordered. Laboratory services will be available on-site, seven days a week, 24 hours a day with a licensed outside diagnostic service that meets all applicable certification standards and local or state	F 157		

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F 157	Continued From page 5 regulations. All diagnostic results are reported to the attending physician/advanced practice nurse (APN)/physician assistant promptly. Practice Standards verify order for laboratory, diagnostic testing and parameters for reporting. Notify diagnostic service to arrange for test. Obtain report of diagnostic report.			
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This Requirement is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to provide the following: 1. Failed to provide privacy while being transported to the shower for 1 of 15 sampled residents (7), 2. Failed to honor 1 of 15 sampled resident's (5) requests to use an alternative blood pressure cuff and not to receive a medication that caused loose stools, and 3. Failed to ensure that four of 8 alert residents in group meeting stated they were not treated with respect by staff. This failure had the potential to cause the residents to feel ignored, embarrassed, and disrespected within their home. Findings:	F 241	**F241 Dignity and Respect of Individuality** **Immediate Corrective Action:** a. Upon notification of the alleged deficient practice resident was provided with privacy going forward by the nursing staff when being transported to the shower. The Nurse Practice Educator provided a re-education to CNA 6 re: Dignity and Respect of resident with emphasis on providing privacy during transport to shower on 11/29/17. b. Upon notification of the alleged deficient practice, Resident 5's request for alternative blood pressure cuff was honored by the licensed nurse going forward.	

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F 157	Continued From page 5 regulations. All diagnostic results are reported to the attending physician/advanced practice nurse (APN)/physician assistant promptly. Practice Standards verify order for laboratory, diagnostic testing and parameters for reporting. Notify diagnostic service to arrange for test. Obtain report of diagnostic report.		c. The Director of Nursing provided education to LVN 50 on 11/29/2017 re: Dignity and Respect of resident re: honoring request of alternative blood pressure cuff Upon notification of the alleged deficient practice, the Director of Nurse provided re-education to LVN 50 on 11/29/2017 on the importance of holding the stool softener of resident when resident has loose/watery stools and the importance of calling the physician if the dose may need to be lowered The Administrator spoke with Resident 5 on 11/3/17 about staff being rough when placing her back to bed. She states that she does not feel that she was purposely trying to cause any harm and that she does not believe that she even aware that she was doing it. The Administrator conducted a 1:1 education with CNA50 on 11/29/17 on Customer Service,	
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This Requirement is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to provide the following: 1. Failed to provide privacy while being transported to the shower for 1 of 15 sampled residents (7), 2. Failed to honor 1 of 15 sampled resident's (5) requests to use an alternative blood pressure cuff and not to receive a medication that caused loose stools, and 3. Failed to ensure that four of 8 alert residents in group meeting stated they were not treated with respect by staff. This failure had the potential to cause the residents to feel ignored, embarrassed, and disrespected within their home. Findings:	F 241		

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F 241	Continued From page 6 a. During observation on November 2, 2017 at 9 a.m., while Resident 7 was being pushed in a shower chair by a Certified Nursing Attendant (CNA 6) in the hallway at nurse station 2, a large bulk of stool dropped and urine spilled on the floor. There were multiple staff and residents present in the hallway. During an interview November 2, 2017 at 9:15 a.m., with CNA 6 about the observation of Resident 7 who had a large bulk of stool drop and urine spilled on the floor, stated sometimes the residents used the restroom on the way to the shower. However, CNA 6 stated it was nothing they could do about it if the resident was incontinent (unable to control the passing stools and urine). During an interview November 2, 2017 at 3:55 p.m., with the Director of Staff Development (DSD) about Resident 7 having a large bulk of stool drop and urine spilled on the floor, stated the facility did not have shower chairs to catch urine or stool. The DSD further acknowledged it could be an embarrassing for the residents that do not have control and have accidents on the floor. A review of Resident 7's facesheet revealed an admission date of December 29, 2016 with diagnoses of muscle wasting, difficulty in walking, and dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities).	F 241	Abuse Prohibition, and Answering Call Lights in a manner that maintains or enhances Dignity and Respect. **d.** The Administrator spoke with RSR19, RSR20, RSR21 and RSR22 about their concerns of staff not treating them with respect. RSR 19, RSR21, and RSR22 expressed general concerns of staff's way of response when speaking to them. Nurse Practice Educator initiated in-services to center staff on Resident's Rights, Customer Service, Abuse Prohibition, and Answering Call Lights in a manner that maintains or enhances Dignity and Respect. After speaking with RSR20, Administrator conducted a 1:1 education with the alleged CNA on 12/1/17 on Abuse Prohibition and Customer Service with emphasis on treating residents with dignity and respect. **Potential Residents that can be affected:**	

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F 241	Continued From page 7 The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated September 14, 2017 indicated Resident 7 had a long term memory problem, required extensive assistance for activities of daily living (bed mobility, dressing, and personal hygiene), and was always incontinent both bowel and bladder. A review of the facility's policy and procedure titled, "Treatment: Considerate and Respectful," with a revision date of September 1, 2013, indicated Genesis HealthCare will promote care for patients in a manner and in an environment that maintains or enhances each patient's dignity and respect in full recognition of his or her individuality. The policy continued to define, "Dignity" means that in their interactions with patients, staff carry out activities that assist the patient to maintain and enhance his/her self-esteem and self-worth. b. A review of Resident 5's admission record indicated she was admitted to the facility on July 15, 2015 with a diagnoses of hypertension (high blood pressure), anxiety (an emotion characterized by an unpleasant state of inner turmoil, often accompanied by nervous behavior), and diverticulum of the esophagus (a pouch, or pocket, of stretched tissue that develops anywhere along the esophagus, pushing outward through its muscular wall). A Minimum Data Set (MDS), a standardized resident assessment and care screening tool), dated, October 7, 2017 indicated Resident 5 had minimum impairment in her cognitive skills for daily-decision making and required extensive to total assistance from staff with activity of daily	F 241	a. The Maintenance Director checked all the shower chair and shower beds on 11/27/17 for any missing containers that will catch any stool or urine. Containers were ordered on 11/27/17 and delivered on 11/28/17 to ensure that each shower chair and shower bed will have a container. b. All residents have the potential to be affected, therefore the Nurse Practice Educator initiated in-services on 11/29/17 to center staff on Residents' Rights, which includes Respecting Resident's Requests, Customer Service, Abuse Prohibition, and Answering Call Lights in a manner that maintains or enhances Dignity and Respect. In-services will be completed by 12/7/17. c. The Department Managers, or designee will interview residents during daily rounds to determine if other residents are experiencing issues with staff not treating them with respect and not answering call lights in a timely manner and interviews will be completed by 12/7/2017	

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F 241	Continued From page 8 living. During an observation of a medication pass on November 2, 2017, Resident 5 was observed stating to LVN 50 she do did not want her blood pressure (BP) checked with the manual BP cuff, she would prefer the wrist one. LVN 50 continued to check the resident's BP even after repeatedly requesting her to stop. Resident 5 was visibly upset and crying, after LVN 50 finish resident was shaking and crying. During an interview Resident 5 also reported to LVN 50 she did not want to take the stool softener because it "has her going. Lately her stools have been watery. Resident 5 asked LVN 50 did they lower the dose of the stool softener, she would then take it." LVN 50 replied, yes the dose had been lowered. However the prescription dated September 11, 2016 of Docusate Sodium 200 milligrams (MG) by g-tube was the same dose and had not been reduced. During an interview with Resident 5 on November 1, 2017 at 2 pm, stated the Certified Nursing Attendant (CNA 50) was rough when placing her back to bed. The resident further stated the staff took too long to answer call lights and sometimes they took longer than 15 minutes. During an interview with CNA 50 on November 7, 2017 at 8:20 a.m., stated was supposed to taken care of Resident 5 on October 30, 2017. When the medication nurse asked if CNA 50 could put the resident back to bed Resident 5 replied "oh no". CNA believe medication nurse put her back to bed that day. State the only thing she could think of, is that one day she forgot to place	F 241	Findings will be reported to the Administrator, Director of Nursing and the Nurse Practice Educator. Additional in-services will be provided as necessary. **System Change:** a. The Nurse Practice Educator initiated in-services on 11/29/17 to nursing staff on ensuring that shower chairs have containers that will catch any stool or urine to maintain or enhance Dignity, Respect, and Privacy of the residents. In-services will be completed by 12/7/17. The Department Managers, or designee will check that residents are provided privacy during transport to shower and the containers are in the shower chairs/beds. b. The Nurse Practice Educator initiated in-services to center staff on Resident's Rights with an emphasis on respecting resident's requests, Customer Service, Abuse Prohibition, and Answering Call Lights in a manner that maintains or	

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F 241	Continued From page 9 resident bed control back by her bed. Resident requested for her not to be her nurse. A review of Resident 5 Activity of Daily living (ADL's), indicated Resident 5 had watery stools on October 31, 01, 02, 2017. The resident was never assessed for her watery stools by a licensed staff member. c. During a group meeting at the facility on November 2, 2017, four of 8 alert residents complained that staff treat them with no respect. c 1. A review of RSR 19 clinical records indicated admitted to the facility on March 13, 2017 with a diagnoses that included heart failure and major depressive disorder. MDS assessment indicated RSR 19 had no impairment in her cognitive skills for daily decision-making and required extensive assistance from staff for ADL's. During group interview the residents stated staff speak to them mean and have attitudes. When residents call for staff they respond by saying "what do you want". The staff do not respond to call lights in a timely manner, take 15-20 minutes and sometimes longer to respond on all shifts. During a separate interview with 2 of the residents from group meeting stated CNAs are very disrespectful when speaking to them and they talk to them as if they were kids. c 2. A review of RSR 20 clinical records indicated admitted March 16, 2009 with diagnosis that included Diabetes Mellitus, hypertension, and anxiety. MDS assessment dated August 07, 2017 indicated RSR 20 had no impairments in	F 241	enhances Dignity and Respect. In-services will be completed by 12/7/17. c. The Nurse Practice Educator initiated in-services to center staff on Customer Service, Treatment of Residents: Considerate and Respectful and Answering Call Lights in a manner that maintains or enhances Dignity and Respect. In-services will be completed by 12/7/17. The Department Managers, or designee, will interview residents during daily rounds weekly for 4 weeks then monthly for 2 months and the Activity's Director will conduct Resident Council meeting monthly in the next 3 months and discuss staff treatment of residents with respect and call lights are being answered in a timely manner. Findings will be reported to the Director of Nursing and Administrator for review. Additional in-services will be provided, as needed.	

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F 241	Continued From page 10 her cognitive skills for daily decision-making and required extensive to limited assistance with her ADL's. During an interview RSR 20 stated one CNA asked her to spread her cheeks while providing peri-care and was very mean. When asked to assist her, CNA's facial expressions was like she did not want to be bothered. The CAN make her feel as if she did something wrong. The resident stated the staff's action made her feel terrible. c 3. A review of RSR 21 clinical records indicated admitted to the facility April 19, 2013 with diagnosis that included Dysphagia, muscle spasms, and history of falls. MDS assessment dated August 2, 2017 indicated RSR 21 had no impairment in her cognitive skills for daily-decision making and required extensive to supervised assistance from staff for ADL's. c 4. A review of RSR 22 clinical records indicated admitted to the facility July 14, 2017 with diagnosis that included respiratory failure, Dysphagia, and hypertension. MDS assessment dated October 19, 2017 indicated RSR 22 had moderate impairment in her cognitive skills for daily decision- making and required extensive to total assistance from staff for ADL's.	F 241	**Monitoring:** The outcomes of the Department Manager Rounds and Resident council Meeting shall be reported by Administrator and the Director of Nursing to the monthly Quality Assurance and Performance Improvement Committee for at least three months. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed. **Completion Date:** December 7, 2017	
F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 242	**F242 Self Determination- Right to Make Choices** **Immediate Corrective Action:** Upon notification of the alleged deficient practice, resident 14's request was honored moving forward re: the choice of the	

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F 241	Continued From page 10 her cognitive skills for daily decision-making and required extensive to limited assistance with her ADL's. During an interview RSR 20 stated one CNA asked her to spread her cheeks while providing peri-care and was very mean. When asked to assist her, CNA's facial expressions was like she did not want to be bothered. The CAN make her feel as if she did something wrong. The resident stated the staff's action made her feel terrible. c 3. A review of RSR 21 clinical records indicated admitted to the facility April 19, 2013 with diagnosis that included Dysphagia, muscle spasms, and history of falls. MDS assessment dated August 2, 2017 indicated RSR 21 had no impairment in her cognitive skills for daily-decision making and required extensive to supervised assistance from staff for ADL's. c 4. A review of RSR 22 clinical records indicated admitted to the facility July 14, 2017 with diagnosis that included respiratory failure, Dysphagia, and hypertension. MDS assessment dated October 19, 2017 indicated RSR 22 had moderate impairment in her cognitive skills for daily decision- making and required extensive to total assistance from staff for ADL's.		resident's spouse to dress and clean him as preferred. **Potential Residents that can be affected:** The Department Managers/IDT shall conduct a review of residents who have preferences for their spouse or family member to dress and clean them as they prefer. Residents identified during this review will have their care plans updated to reflect residents' preferences by 12/7/2017 The Nurse Practice Educator initiated re-education to Nursing Staff re: Policy and Procedure on Resident's Rights with emphasis on honoring residents' rights to have their family clean and dress them as requested. Education to be completed by 12/7/2017 The Administrator provided re-education to the Department Managers and IDT re: Policy and Procedure on Resident's Rights with emphasis on honoring	
F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 242		

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F 242	Continued From page 11 (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This Requirement is not met as evidenced by: During observation, interview and record review, the facility failed to honor one of 15 sampled residents (14) choice for their spouse to clean and dress him. This deficient practice caused the resident to feel embarrassed. Findings: During an interview on November 3, 2017 at 12:10 p.m. with Resident 14 stated he wanted his wife to wash him and get him dressed. Resident 14 further stated he felt embarrassed when the staff wash his private area. An interview on same day and time with Resident 14's family member stated they have told the nurses before but the nurses always tell them, "No." During an interview with Certified Nurse Assistant (CNA 5) on November 3, 2017 at 12:20 p.m. stated she was aware Resident 14's wife wanted to wash the resident, but only CNAs clean the resident. During an interview on November 3, 2017 at	F 242	residents' rights to have their family help clean and dress them as requested on 12/1/17. **Process to Prevent Reoccurrence:** During Care Plan Meetings with residents and their families, preference with care will be discussed to assure that residents' requests are honored. Requests or preferences re: care will be care planned. During Morning Stand up Meeting, the IDT shall report to the Administrator for further follow up concerns identified during the care plan meetings re: honoring residents' requests and preference to be followed **Monitoring:** Administrator shall present the results on the review of the resident's preference for care to the Quality Assurance and Performance Committee for	

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F 242	Continued From page 12 12:35 p.m. with Director of Staff Development (DSD) stated if Resident 14 wanted his wife to wash him then she should be able to clean him, if she and he agreed upon that. DSD further stated because it was the resident's rights. A review of Resident 14's facesheet indicated an admission date of October 5, 2017 and diagnosis angina pectoris (chest pain) and shortness of breath. Review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated October 12, 2017, Resident 14 was deemed as cognitively intact and the preferred language for communication was indicated to be Spanish. According to the facility's policy and procedure (P&P) with a revision date of November 28, 2016 and titled, "Resident Rights Under Federal Law," indicated Genesis Healthcare patients have the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social, and spiritual values. The P&P further indicated to recognize each patient's individuality, and to protect and promote the rights of the patient.	F 242	review and recommendations monthly for three months then quarterly thereafter until substantial compliance is achieved. **Completion Date:** December 7, 2017	
F 248 SS=E	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES CFR(s): 483.24(c)(1) (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 248	**F248 Activities Meet Interests/Needs of Each Resident** **Immediate Corrective Action:**	

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F 248	Continued From page 13 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This Requirement is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to provide the Spanish activities calendars for one of 15 sampled residents (14) and one of 6 randomly sampled residents (RSR 18). This failure had the potential to cause the residents with limited English proficiency have meaningful access and an equal opportunity to participate in the services program. Findings: a. During an observation and interview with Resident 14 on November 3, 2017 at 12 p.m., in the resident's room there was an English activities calendar on the wall in front of the bed. During an interview the resident stated a Certified Nurse's Assistants (CNAs) come to pick him up and takes him to activities. The resident further stated he was unable to read the calendar because it was in English. The resident stated he preferred a Spanish calendar to be aware of what was happening in activities without the staff's assistance. A review of Resident 14's facesheet indicated an admission date of October 5, 2017 and diagnosis of diabetes mellitus (abnormal blood sugar).	F 248	Activity Director spoke to Resident 14 and RSR 18 on 11/29/17 about their preference for a Spanish activities calendar instead of an English calendar. A daily activity calendar written in Spanish was given to Resident 14 and RSR18 for the remainder of the calendar month, but RSR18 stated that she did not want a Spanish activities calendar, but instead wanted a yearly calendar in Spanish. A yearly Spanish calendar was given to RSR18. **Potential Residents that can be affected:** The Activities Director interviewed all residents whose dominant language is Spanish to ask if they would prefer a Spanish activities calendar. Those who requested for a Spanish calendar were provided one. Any further requests will be honored. **System Change:** The Administrator educated the Activity Director on providing	

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F 248	Continued From page 14 During a review of the Minimum Data Set (MDS), a standardized assessment and care screening tool dated October 12, 2017, indicated Resident 14 was deemed as cognitively intact and the preferred language for communication was coded as Spanish. During an interview with the Activities Director (AD) on November 3, 2017 at 4 p.m., stated there were no Spanish activity calendars for the Spanish speaking residents. The AD further stated she never thought about providing a calendar in Spanish for the residents to read in their dominant language. b. During an observation and interview with RSR 18 on November 3, 2017 at 4:20 p.m., there was an English activity calendar in front of the bed. During an interview the resident stated, "I need a Spanish activity calendar, can't read English." A review of RSR 18's facesheet indicated a re-admission date of July 23, 2015 and diagnosis of major depressive disorder (a mental disorder characterized by a persistent low mood). During a review of the Minimum Data Set (MDS), a standardized assessment and care screening tool dated October 1, 2017, indicated RSR 18 was deemed as cognitively intact and the preferred language for communication was coded as Spanish.	F 248	Spanish activities calendars to those who request or prefers to have them on 11/29/17. The Activities Director will ask all newly admitted residents whose dominant language is Spanish about their preference for a Spanish activities calendar and provide as requested. Any concerns shall be reported to the Administrator. **Monitoring:** The outcome of the interviews will be reported by the Activities Director to the monthly Quality Assurance and Performance Improvement Committee for at least three months. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed. **Completion Date:** December 7, 2017	

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F 248	Continued From page 15 A review of the facility's policy and procedure with a revision date of October 18, 2016 titled, "Communication with Persons with Limited English Proficiency (LEP)," indicated Genesis Healthcare will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in the services, activities, programs, and other benefits as provided by Genesis Healthcare service locations. The policy further indicated to improve access to care, quality of care, and health outcomes for patients with culturally diverse communication and language needs.			
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279	**F279 Develop Comprehensive Care Plans** **Immediate Corrective Action:** a. Resident 1's Care Plan for Risperdal was updated on 11/7/17 by the Clinical Reimbursement Coordinator (CRC) to include the Black Box Warning (BBW) with the side effects and significant risks from the medication. An In-service Training was given to the Licensed Nurses on 11/6/17 by the DON on including the BBW in the Care Plan when a resident is admitted with antipsychotic medications such as Risperdal and other similar drugs that may cause serious infections,	

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F 279	Continued From page 16 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and implemented the care plans for two of 15 sampled residents (1 and 10). The deficient practice created the potential for the	F 279	severe and potentially harmful effects to the body organs, leading to hospitalization or death. b. A Plan of care was completed by the DON on 11/2/17 on Care of Residents on Digoxin including concerns and nursing interventions and BBW. An In-service Training was given to the Licensed Nurses on 11/2/17 by the DON on writing Care Plan for residents on Digoxin including concerns, nursing interventions and potential medication side effects. **Potential Residents that can be affected:** The Director of Nursing, Health Information Manager, and Clinical Reimbursement Coordinator (CRC) reviewed all medical records of the residents who are on Digoxin. No other residents were identified having the same deficiency.	

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F 279	Continued From page 17 delay in care and services to resolve the residents' assessed concerns. Findings: a. According to the facility's admission records Resident 1 was readmitted into the facility on 09/08/2013, with diagnoses that included psychosis (mental condition that causes you to lose touch with reality) with delusions (false beliefs that a person firmly holds to be true) due to known physiological condition. The Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 10/14/2017, indicated Resident 1's speech was unclear. The resident was usually understood and able to understand others. The resident's daily decision making skills were moderately impaired. The resident's potential indicators of psychosis indicated no hallucinations nor delusions. A record review of the recapitulated 11/2017 physician's orders for Resident 1 indicated Risperdal tablet 2 milligram (mg [treats certain mental/mood disorders]) at bedtime for psychosis manifested by inappropriate touching of female staff. During a record review in the presence of the Minimum Data Set (MDS) Nurse on 11/6/2017 at 5 p.m., Resident 1's plan of care had no Black Box Warning (the side effects and significant risks from the medication) Risperdal.	F 279	**System Change:** The Licensed Nurses were given in-service training by the DON on 11/29/17 and 11/30/17 re: the Policy and Procedures for Care Planning with emphasis on Black Box Warning and Digoxin Care Plans. Education will be completed by 12/7/2017. Licensed nurses upon receipt of a new order for Risperdal and Digoxin shall ensure that a person centered care plan is developed which includes instructions needed to provide effective care to the residents. **Monitoring:** The HIM/Unit Manager shall review new orders of Digoxin and Risperdal during morning clinical meeting to ensure that care plans are completed by the licensed nurses. Concerns identified will be reported immediately to the Director of Nurses for follow up as warranted. The results of the Risperdal and Digoxin Care Plan Audit will be	

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F 279	Continued From page 18 During an interview on 1/6/2017 with the MDS Nurse she stated she forgot to include the Risperdal's Black Box Warning on Resident 1's plan of care. The MDS Nurse stated she forgot to include the Black Box warning on the resident's plan of care. b. According to the admission record Resident 10 was admitted to the facility on 8/18/2017, with diagnoses that included cerebral infarction (blockage in the blood vessels supplying blood to the brain), heart failure (inability to pump an adequate supply of blood). The Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 8/25/2017, indicated Resident 10's speech was clear, the resident was able to make himself understood and understood others. The resident's cognitive skills for daily decision making was moderately impaired. A record review of Resident 10's clinical records failed to show a plan of care written for Digoxin medication administered daily, indicating medication concerns and nursing interventions. During an interview on 11/02/2017 with RN 2 at 11 a.m., stated the nursing staff should have developed the plan of care for the medication Digoxin administered to Resident 10, that included concerns and nursing interventions for potential medication side effects.	F 279	presented by the DON to the Quality Assurance Performance Improvement Committee for further review and recommendations monthly for 3 months then quarterly thereafter until substantial compliance is achieved. **Completion Date:** December 7, 2017	

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F 279	Continued From page 19 According to the facility's policy and procedures titled, 'Person Centered-Care Plan', dated 11/28/2016, indicated the center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality of care.			
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet professional standards by identifying, reporting and monitoring a change of condition for one of 15 sampled residents (5) for having loose stools. This deficient practice had the potential to place resident in risk of dehydration (loss of too much fluid). Findings: A review of Resident 5's admission records indicated she was admitted to the facility on July 15, 2015 with a diagnoses of hypertension (high blood pressure), anxiety (an emotion characterized by an unpleasant state of inner	F 281	**F281 Services Provided Meet Professional Standards** **Immediate Corrective Action:** The Director of Nursing (DON) conducted 1:1 in-service training with LVN50 on 11/2/17 on providing professional standards of care to residents by identifying, reporting and monitoring a change of condition. CNA54 was provided an education by the Nurse Practice on the importance of notifying the charge nurse when a change of condition, such as a loose stool is identified. LVN 51 was provided reeducation regarding changes in condition reported by CNA during the shift are followed up in a timely manner	

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F 279	Continued From page 19 According to the facility's policy and procedures titled, 'Person Centered-Care Plan', dated 11/28/2016, indicated the center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality of care.		LVN 51 was provided reeducation regarding changes in condition reported by CNA during the shift are followed up in a timely manner and their responsibility regarding communicating and inquiring with CNAs about any changes in condition with the residents.	
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet professional standards by identifying, reporting and monitoring a change of condition for one of 15 sampled residents (5) for having loose stools. This deficient practice had the potential to place resident in risk of dehydration (loss of too much fluid). Findings: A review of Resident 5's admission records indicated she was admitted to the facility on July 15, 2015 with a diagnoses of hypertension (high blood pressure), anxiety (an emotion characterized by an unpleasant state of inner	F281	**Potential Residents that can be affected:** The Director of Nursing and the Health Information Manager (HIM) will review the Bowel movement report for loose stools to ensure that stool softener was held or not given by the licensed Nurse. Audit will be completed by 12/7/17. Residents identified will be immediately addressed and reported to the physician as warranted. **System Change:** Education was initiated by the Nurse Practice Educator to the CNAs regarding policy and procedure on change of condition with emphasis on notifying charges nurses when residents have changes in changes in bowel	

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F 281	Continued From page 20 turmoil, often accompanied by nervous behavior), and diverticulum of the esophagus (a pouch, or pocket, of stretched tissue that develops anywhere along the esophagus, pushing outward through its muscular wall). A Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated October 7, 2017 indicated Resident 5 had minimum impairment in her cognitive skills for daily- decision making and required extensive to total assistance from staff with activity of daily living. During an observation on November 2, 2107, Resident 5 reported to a Licensed Vocational Nurse (LVN 50) she did not want to take the stool softener because it "has her going. Lately her stools have been watery." Resident 5 asked LVN 50 if they lower the dose of the stool softener, she would then take it. LVN 50 replied "yes the dose has been lower." However, a review of the physician order dated September 11, 2016 indicated Docusate Sodium (stool softener) 200 milligrams (MG) by g-tube (a tube through the stomach to deliver nutrition and hydration) was the same dose and had not been reduced. A review of Resident 5 Activity of Daily living (ADL's), indicated Resident 5 had watery stools on October 31, 01, 02, 2017. However, the clinical records did not show if the resident was ever assessed for her watery stools by a licensed staff member. During an interview with LVN 51 on November 6,	F 281	movements to ensure that stool softeners are not given when a loose stool is identified. Education will be completed by 12/7/2017. The Director of Nursing provided reeducation to the Licensed Nurses regarding the Policy and Procedure for Changes in Condition with emphasis in ensuring that changes reported by CNA during the shift are followed up in a timely manner and their responsibility regarding communicating and inquiring with CNAs about any changes in condition with the residents. Education will be completed by 12/7/2017. During nursing shift rounds, residents identified with loose stools will be reported to the charge nurses immediately for further assessments. The licensed nurses will conduct change of shift report with the CNA to ensure that changes in condition are followed up in a timely manner.	

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F 281	Continued From page 21 2107, stated LVN's are responsible for checking if Resident 5 had loose stools. LVN 51 stated there was no way to know if they do not see the bowel movement themselves. LVN 51 state she did not follow up regarding the resident's bowel movement this morning. During a phone Interview with a Certified Nursing Assistant (CNA 54) on November 7, 2017, stated Resident 5 stools was watery, but did not report it because it was only one time. However, the clinical records dated November 1, 2017 showed Resident 5 had several loose stools. During interview with CNA 52 on November 7, 2017 at 1:30 p.m., stated Resident 5 had runny (loose) stools on Sunday November 5, 2017 and reported to LVN 51.	F 281	The Health Information Manager will conduct an audit of the bowel movement record to identify loose stools and will also conduct an audit of the Medication Administration Record for stool softeners to ensure that stool softeners are not given or withheld with residents with loose stools weekly for 4 weeks then monthly for 2 months. Results will be reported to the Director of Nursing for review and follow up. **Monitoring:** The Director of Nursing will bring the results of the bowel movement and stool softener audit to the Quality Assurance Performance Improvement for further recommendations monthly for three months, then quarterly thereafter until substantial compliance is achieved. **Completion Date:** December 7, 2017	
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide proper oral hygiene and apply lotion to the skin after a shower for one of 15 sampled residents (7). This deficient practice had the potential to cause the resident to have dry, cracked skin, poor oral health, and a decrease sense of well- being. Findings:			

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F 281	Continued From page 21 2107, stated LVN's are responsible for checking if Resident 5 had loose stools. LVN 51 stated there was no way to know if they do not see the bowel movement themselves. LVN 51 state she did not follow up regarding the resident's bowel movement this morning. During a phone interview with a Certified Nursing Assistant (CNA 54) on November 7, 2017, stated Resident 5 stools was watery, but did not report it because it was only one time. However, the clinical records dated November 1, 2017 showed Resident 5 had several loose stools. During interview with CNA 52 on November 7, 2017 at 1:30 p.m., stated Resident 5 had runny (loose) stools on Sunday November 5, 2017 and reported to LVN 51.			
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide proper oral hygiene and apply lotion to the skin after a shower for one of 15 sampled residents (7). This deficient practice had the potential to cause the resident to have dry, cracked skin, poor oral health, and a decrease sense of well- being. Findings:	F 312	**F312 ADL Care Provided for Dependent Residents** **Immediate Corrective Action:** Resident 7 was immediately provided with proper oral hygiene and lotion was applied to the skin. The Nurse Practice Educator provided 1:1 education and completed a competency validation with CNA 6 on proper ADL care for showers and oral care on 11/3/17.	

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F 312	Continued From page 22 During an observation on November 2, 2017 at 9 a.m., before, during, and after Resident 7 was showered by a Certified Nursing Attendant (CNA 6) no lotion was applied to the skin and no oral care was completed. During an interview on November 2, 2017 at 3:55 p.m. with the Director of Staff Development (DSD) stated that all residents should have lotion applied to their skin after showers and have their mouths cleaned, as well. A review of Resident 7's facesheet revealed an admission date of December 29, 2016 with diagnosis of muscle wasting, difficulty in walking, and dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). Review of the Minimum Data Set (MDS), a standardized assessment and care screening tool, dated September 14, 2017 indicated Resident 7 had a long term memory problem and required extensive assistance for activities of daily living (bed mobility, dressing, and personal hygiene.) According to the facility's policy and procedure dated November 28, 2016, titled, "Accommodation of Needs," indicated to accommodate resident's needs and preferences." A review of the "Clinical Competency Validation	F 312	**Potential Residents that can be affected:** All residents have the potential to be affected, therefore the Nurse Practice Educator initiated in-services on 11/29/17 to nursing staff on proper ADL Care for showers and bed baths. Nurse Practice Educator also initiated Competency Validations for Shower Baths and Mouth Care on 11/29/17 and will be completed by 12/7/17. RN Supervisor conducted resident rounds to ensure that proper oral hygiene was provided and checked for dry skin. No other deficient practice were identified. **System Change:** The Nurse Practice Educator initiated in-services on 11/29/17 to nursing staff on proper ADL Care for showers and bed baths. Nurse Practice Educator also initiated Competency Validations for Shower Baths and Mouth Care on 11/29/17 and will be completed by 12/7/17.	

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F 312	Continued From page 23 Shower Bath" form dated for January 2016, indicated during bath time to apply moisturizing lotion.	F 312	The RN Supervisors, or designee will make observations during their daily rounds to ensure that staff are providing proper oral hygiene and lotion is applied after showers and bed baths. Findings will be reported to the Director of Nursing for review. Additional in-services will be provided, as needed. **Monitoring:** The outcome of the observations will be reported by the Director of Nursing to the monthly Quality Assurance and Performance Improvement Committee for at least three months. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed. **Completion Date:** December 7, 2017	
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;			

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F 312	Continued From page 23 Shower Bath" form dated for January 2016, indicated during bath time to apply moisturizing lotion.			
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329	**F329 Drug Regimen is Free From Unnecessary Drugs** **Immediate Corrective Action:** On 11/18/17 The Director of Nursing (DON) notified Resident 1's Psychiatrist about the targeted behavior for Risperdal. The targeted behavior of resident for use of Risperdal was clarified to a new behavior manisfestation. On 10/24/17 Resident 1 was evaluated by the Psychiatrist and deemed that the Risperdal was appropriate for continued use. **Potential Residents that can be affected:** The Director of Nursing and Health Information Manager will conduct a review of residents with orders for antipsychotic medications to ensure that the targeted behaviors are appropriate for the continued use of the	

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F 329	Continued From page 24 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's drug regimen was free of an unnecessary drug related to the lack of indications for its use, ongoing monitoring for the continued use of the medication Risperdal (treats certain mental/mood disorders) tablet 2 milligram (mg) at bedtime for psychosis manifested by inappropriate touching of female staff for one of 15 sampled residents (1). The deficient practice increased the potential risk of Resident 1 experiencing adverse reactions (any unexpected or dangerous reaction to a drug) such as falls and confusion. Findings: According to the facility's admission records Resident 1 was readmitted into the facility on 09/08/2013, with diagnoses that included psychosis (mental condition that causes you to lose touch with reality) with delusions (false beliefs that a person firmly holds to be true) due to known physiological condition. The Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 10/14/2017, indicated Resident 1's speech was unclear. The resident was usually understood and able to understand others. The resident's daily decision making skills were moderately impaired. The resident's potential for	F 329	medication. Audit will be completed by 12/7/17. Findings or issues identified will be addressed with the Physician/Psychiatrist immediately. **System Change:** The Nurse Practice Educator will initiate a re-education on the policy and procedure on Managing Challenging Behaviors with emphasis on the appropriateness of antipsychotic use and targeted behaviors for continued use. Education will be completed by 12/7/17. Upon receipt of an order of an antipsychotic, the licensed nurse will verify with the physician the appropriate indication and targeted behavior for the continued use of the antipsychotic medication. **Monitoring:** During morning clinical meeting, new orders of antipsychotics will be reviewed by the IDT to assure	

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F 329	Continued From page 25 psychosis behavior indicated no hallucinations nor delusions. A record review of Resident 1's recapitulated 11/2017 physician order indicated Risperdal tablet 2 mg at bedtime for psychosis manifested by inappropriate touching of female staff. A review of Resident 1's clinical records and interview in the presence of the director of nursing (DON) stated Resident 1 was currently receiving routine Risperdal 2 mg at bedtime every day (since 09/27/2017). The DON stated a zero (0) means no behavior and what was documented by the licensed nurses for the resident's behavior should be accurate. A review of the 10/2017 the Behavior Monitoring form indicated Resident 1 had inappropriate behavior manifested by touching of females. However, inappropriate behavioral touching of females was not specific to where and how the female was touched as follows: The Behavior Symptom form on the 11 p.m., to 7 a.m. shift indicated zero episodes. On the 7 a.m., to 3 p.m., shift total of 29 episodes October 1 thru 13, 2017 and October 25, 26 and 29, 2017, a total of three episodes. October 6, 2017 was blank, no documented episode(s). On the 3 p.m., to 11 p.m., shift on 10/1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19 and 30/2017 a total of 30 episodes. October 3, 4, 20, 21, 22, 23, 24 and 31/2017 were blank no documented episodes.	F 329	appropriate indication and targeted behavior. Any issues identified will be reported to the Director of Nursing and Attending Physician/Psychiatrist as warranted. The Director of Nursing will bring the results of the antipsychotic medication review to the Quality Assurance Performance Improvement for further recommendations monthly for three months, then quarterly thereafter until substantial compliance is achieved. **Completion Date:** December 7, 2017	

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F 329	Continued From page 26 A review of the 11/2017 Behavior Monitoring form dated from 11/1/2017 thru 11/6/2017 for Resident 1 indicated as follows; On the 11 p.m., to 7 a.m., shift zero episodes. On the 7 a.m., to 3 p.m., shift zero episodes. On the 3 p.m., to 11 p.m., shift two episodes dated 11 3 and 4/2017; and 11/1, 2 and 5/2017 were blank no documented episodes. During a tour on Station A on 11/2, 3, 4, 5 and 6/2017, at 11 a.m., 2 p.m., 3 p.m., Resident 1 was in his room and lying his bed with a cup of juice in his hand looking out into the corridor. The resident was observed tilting the juice towards the edge of the cup and as the juice became closer to the edge of cup, the resident would bring the cup upright so the juice would not fall out of the cup. During an interview on 11/7/2017 at 10:30 a.m., with Certified Nursing Attendant (CNA 30) stated she had been assigned to Resident 1 two times a week. CNA 30 stated the resident wanted juice all the time and told everybody he wanted juice. CNA 30 stated the resident touches her arm and her uniform. CNA 30 stated the resident was not trying to "hurt me." When asked if she felt threatened by the resident when he touches her, CNA 30 stated never. CNA 30 stated the resident does not touch her "butt, her leg or her face." CNA 30 stated she was not threatened by the resident's touching. During an interview on 11/7/2017 at 12 p.m., with Licensed Vocational Nurse (LVN 26) stated she had been assigned to Resident 1 for one year. LVN 26 stated she had no issues with the	F 329		

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F 329	Continued From page 27 resident. LVN 26 stated the resident touched her on the arm when taking his blood pressure and he played around. LVN 26 stated the resident acted like a five year old all the time. LVN 26 stated she did not feel threatened when the resident touched her. LVN 26 stated the resident did not touch her in a sexual manner but was just trying to get attention. According to the facility's policy titled, 'Psychotherapy Medication Use', revised 01/01/14 the center identifies factors (e.g. environmental and psychological stressors, treatable medical conditions, etc,) that contribute to or are responsible for change in the patient's behavior. Whenever possible and clinically appropriate, Center staff will commend non-drug approaches such as behavioral intervention, environmental modifications, or alternative approaches to care to assist in the treatment or modification of the patient's behavior. If drug therapy with a psychotherapeutic drug is indicated, the physician, Center staff and consultant pharmacist work together in selecting the most effective drug with the fewest potential side effects, lowest risk of adverse drug reaction, and in the lowest effective does for that patient. Staff will comply with the Psychopharmacological Dosage Guideline created by the Center for Medicare and Medicaid Services (CMS) and all federal and state applicable law relating to the use of psychotherapeutic medication. Purpose to ensure patients are prescribed psychotherapeutic drugs for appropriate indications, dosages, length of treatment, and duration.	F 329		
F 332 SS=E	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1)	F 332	F332 Free of Medication Error Rates of 5% or More	

Printed: 11/22/2017
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OMB NO. 0938-0391

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F 332	Continued From page 28 (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the residents received medications as prescribed and failed to maintain an error rate of less than five (5) percent for three medication errors for 27 opportunities for error resulting in a cumulative error rate of 18 percent (5, 6, and 7). Resident 5 was administered Verapamil (treats hypertension [high blood pressure]), angina (chest pain), and certain heart rhythm disorders without checking for the pulse rate. Resident 6 medications (6 tablets) were all crushed together and her eye drops (Azopt) was not administered adequately. Resident 7 was given the incorrect dosage for Calcium with Vitamin D, Levetiracetam ([Keppra] used to treat seizures) was crushed while the instructions indicated not to crush. These deficient practices had the potential to alter the compound of the medications creating an abnormal reaction, dropping heart rate below normal rate, and not receiving medication as prescribed can cause a delay in treatment for the residents. Findings: a. A review of Resident 5's admission records	F 332	**Immediate Corrective Action:** a. The DON reviewed with LVN 50 Medication-Related Errors on Medication Administration of Verapamil giving emphasis on taking the heart rate before administering. Resident's HR was rechecked by the licensed nurse and found to be within normal range. b.1. The DON reviewed with LVN 50 Medication-Related Errors on proper procedure of Medication Administration of multiple medications. Resident had no adverse reaction to the medications being given together after being crushed. b.2. The DON reviewed with LVN 50 Medication-Related Errors on Procedure of eye drops / ointment Administration. The attending physician was notified of the error the same day and gave no new orders and resident did not have any adverse reaction to the alleged deficient practice	

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F 332	Continued From page 29 indicated she was admitted to the facility on July 15, 2015 with a diagnosis of hypertension (high blood pressure), anxiety (an emotion characterized by an unpleasant state of inner turmoil, often accompanied by nervous behavior), and diverticulum of the esophagus (is a pouch, or pocket, of stretched tissue that develops anywhere along the esophagus, pushing outward through its muscular wall). A Minimum Data Set (MDS), a standardized resident assessment and care screening tool), dated October 7, 2017 indicated Resident 5 had minimum impairment in her cognitive skills for daily-decision making and required extensive to total assistance from staff with activity of daily living. During a medication pass observation for Resident 5 on November 2, 2107 at 8:50 a.m., with Licensed Vocational Nurse (LVN 50), the Verapamil (antihypertensive) 40 milligrams (MG) was administered through a gastrostomy feeding tube ([g-tube] placement of a feeding tube through the skin and the stomach wall that goes directly into the stomach). LVN 50 took the resident's blood pressure (128/72 milligram per mercury [mm/Hg]), but failed to take the heart rate before administering Verapamil. During a review of Resident 5's physician order indicated to give one tablet through the g-tube four times a day, hold for systolic blood pressure (top part of the blood pressure) for less than 110 mm/Hg and for heartrate less than 60 beats per minute.	F 332	The Nurse Practice Educator (NPE) conducted a Clinical Competency Validation on Eye (Drops or Ointments) Medication Administration with LVN 50 on 11/2/17. c.1. On 11/2/17 The DON reviewed with LVN 12 Medication-Related Errors on Administration of the Correct Medication as ordered. The Attending Physician was notified of the Medication Error. Clarification of order for Calcium and Vitamin D was done. Correct Medication Supplement was dispensed from Oyer-the Counter Med Supply to the resident's cart on 11/2/17. c.2. The DON reviewed with LVN 12 Medication-Related Errors on Crushable Medications on 11/2/17. Order was received from the Attending Physician by LVN 12 to change the medication from Oral Tablet to Solution. **Potential Residents that can be affected:**	

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F 332	Continued From page 30 During an interview with LVN 50 on November 2, 2017 at 9:15 a.m., stated Resident 5 heart rate usually ran around 70 beats per minute. LVN 50 stated "To be honest I may have skipped Resident 5 this morning." b 1. A review of Resident 6 admission records indicated she was admitted to the facility on September 21, 2017 with diagnoses that included history of falling and cellulitis (a common and potentially serious bacterial skin infection) of the chest wall. The Minimum Data Set (MDS), a standardized resident assessment and care screening tool, indicated Resident 6 had minimum impairment in her cognitive skills for her daily decision making and required extensive assistance from staff with activity of daily living. During medication pass observation for Resident 6 on November 2, 2017 at 9:30 a.m., observed a Licensed Vocational Nurse (LVN 50) placed an Iron table 325 mg (one tablet), stool softener 100 mg (one tablet), Multivitamins with minerals (one tablet), Zinc sulfate 220 mg (one tablet), Xarelto 15 mg (one tablet), Vesicare 5 mg (one tablet) all in one plastic bag and crushed medications together. LVN 50 then placed the medications in applesauce and then administered them to the resident. During the medication administration there was green and white residue still observed left in medication cup. LVN 50 stated that it was the Iron medication that was green that was observed in cup. However, LVN 50 did not retrieve all the medication out of the medication	F 332	The Nurse Practice Educator/Director of Nurses shall conduct Medication Administration Observation/Competency with the Licensed Nurses with special focus on checking pulse for meds with parameters, administration of eye gtts, crushing of meds, and ensuring correct dosage of medication given by 12/7/2017. **System Change:** In-service Training was conducted by the DON to Licensed Nurses on Multiple Medication Administration on 11/29/17 and 11/30/17. The education will be completed by 12/7/2017. In-service Training on Medication Error Rates on Verapamil, Multiple Medications, Eye Drops, Calcium and Vitamins, and Keppra Solutions including the Medication Audits Results was conducted by DON on 11/29/17 and 11/30/17 and this in-service will be completed by 12/7/2017	

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F 332	Continued From page 31 cup. b 2. During the medication administration on November 2, 2017 at 9:30 a.m., LVN 50 administered eye drops (Azopt 1 percent) to Resident 6 right eye. However, the medication was placed on top of the resident's right eye lid and then wiped off by LVN 50. The left eye drop was placed on the eye lids. The resident did not receive the eye drops as ordered. During an interview with LVN 50 on November 2, 2017 at 3:51 p.m., she acknowledged the proper procedure to place eye drops/ointment, was by lifting top eye lid and eye drops should hit the white part of the eye. During interview with Director of Staff Developer (DSD) on November 6, 2017 at 11:45 a.m., stated medication should be crushed separately, that was supposed to be one by one medication. To mix well in applesauce and the resident did not get all the medication if residue was still left in cup. The facility's policy and procedure titled "Medication Administration: Eye drops and Ointments" dated January 2, 2014, indicated to cleanse hands, put on gloves. Holding eye drops in dominant hand, use other hand to gently pull down lower lid. For drops, instill drops in conjunctiva sac, avoid placing drops directly on eyeball or touching eye with tip of container. For ointments, squeeze a small ribbon of medication on the edge of the conjunctiva sac from the inner to the outer canthus (is either corner of the eye	F 332	**Monitoring:** The DON/NPE or Pharmacy nurse consultant will conduct Medication Administration observations of 5 Licensed Nurses every 2 weeks in the next 3 months and the results will be reviewed by the Director of nurses for further follow up The Director of Nurses shall present the outcome of the Medication Administration Observation/ Audits to the Quality Assurance and Performance Committee for review and recommendations monthly for 3 months then quarterly thereafter until substantial compliance is achieved. **Completion Date:** December 7, 2017	

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F 332	Continued From page 32 where the upper and lower eyelids meet). c 1. During a medication pass observation on November 17, 2017 at 8:07 a.m., with Licensed Vocational Nurse (LVN 12) gave 1 green tablet from the bottle that read, "Calcium with Vitamin D 500 mg," 200 I.U. (international units) of vitamin D3 to Resident 7. However, during a review of Resident 7's physician order it indicated to administer Calcium 600/Vitamin D3 tab (600-800 mg-unit). c 2. During an observation on November 17, 2017 at 8:07 a.m Levetiracetam ([Keppra] treat seizures) 500 mg was crushed by LVN 12. LVN 12 stated , "It's not crushable, but I'll use my judgement," and continued to crush the medication and gave it to Resident 7 in applesauce. However, on the label of the bottle of Levetiracetam read, "Do Not Crush." During an interview with LVN 12 on November 2, 2017 at 3:27 p.m., stated Keppra was not to be crushed and he should have called the pharmacy for another form of the medication. A review of the medical literature titled "Keppra (Levetiracetam): Breaking or Crushing Tablets," from the pharmacist consultant indicated prescribing information, Keppra (levetiracetam) tablets should be swallowed whole and should not be chewed or crushed.	F 332		

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F 332	Continued From page 33 A review of the facility's policy and procedures revised on January 2, 2014, titled "Medications Errors," indicated a medication error is defined as a discrepancy between what the physician/mid-level provider ordered and what the patient received. The types of errors include; medication omission; wrong patient, dose, route, rate, or time; incorrect preparation; and/or incorrect administration technique.			
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (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 from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This Requirement is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the staff tested the low	F 371	**F371 Food Procure, Store/Prepare/Serve-Sanitary** **Immediate Corrective Action:** a. The Dietary Aide tested the low temperature dishwasher's final rinse PPM hypochlorite on dishware on 11/3/17. The Food Service Director provided education and competency validation to DA3 on 11/6/17 on proper techniques of taking the low temperature dishwasher's final rinse PPM hypochlorite on dishware. He also educated and completed competency validations with the other dietary staff who assists with warewashing on 11/6/17. b. The solid ice adhered to the sides of the ice cream freezer was removed and cleaned on 11/3/17 by the Dietary Aide. The Food Service Director in-serviced the	

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F 371	Continued From page 34 temperature dishwasher's final rinse parts per million (ppm) hypochlorite (chlorine) on dishware, not the dishwasher's tray and solid ice adhered to each sides of the freezer. The deficient practice placed the residents at potential risk of eating from improper sanitizing, contaminated dishware and improper temperature of the freezer. Findings: a. On 11/3/2017 at 9:30 a.m., observed the low temperature dishwasher's sanitizing final rinse test for the ppm. The Dietary Supervisor (DS) asked Dietary Aide (DA 3) to start the dishwasher's final rinse to demonstrate how the dietary assistant checks the chemical sanitization for a 50 ppm reading. The DA 3 turned on the water to run the low temperature dishwasher's final rinse. DA 3 took the ppm strip and placed the strip into the water at the bottom of the dishwasher and stated the strip reads 50 ppm. Dietary Aide when asked how to test the final sanitizing rinse for the 50 ppm reading, stated dip the strip into the water at the bottom of the dishwasher. During an interview on the 11/2/2017 at 10 a.m., with the Dietary Supervisor stated DA 3 should have tested a dish not the water at the bottom of the dishwasher. b. During an observation of the lunch time food preparation on 11/3/2017 at 10:30 a.m., observed a four by two white Chest Freezer (upright	F 371	in-service on 11/6/17 on the Cleaning Schedule policy & procedure and the Dietary Weekly Cleaning Schedule, which includes cleaning and defrosting of the ice cream freezer. a. The Food Service Director, or designee will conduct random checks to ensure that the dietary staff are checking the low temperature dishwasher's final rinse PPM hypochlorite on dishware properly. Findings will be reported to the Administrator for review. b. The ice cream freezer will be cleaned weekly, per the Dietary Weekly Cleaning Schedule. The Food Service Director, or designee will conduct random to ensure that there are no solid ice adhered to the sides of the freezer. Additional cleaning and defrosting will be conducted, if needed. Findings will be reported to the Administrator for review. **Monitoring:**	

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F 371	Continued From page 35 freezer) in the kitchen's cooking preparation area. The freezer's lid door was observed with frozen ice cream stored in the freezer that had solid ice adhered to each sides of the freezer. According to the facility's policy and procedure policy titled, 'Food and Nutrition Services Policies and Procedures', revised 3/16/2015 indicated the Director of Dining Services or designee records temperatures and sanitizer PPM on dish surface (on low temperature machine).	F 371	The outcome of the audits will be reported by the Administrator to the monthly Quality Assurance and Performance Improvement Committee for at least three months. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed.	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431	**Completion Date:** 12/7/2017 **F431 Drug Records, Label/Store Drugs & Biologicals** **Immediate Corrective Action:** DON removed the expired Jevity 1.5 calorie can on 11/3/17. The unlabeled Lantus insulin was removed and discarded on 11/3/17. **Potential Residents that can be affected:** The Central Supply personnel inspected the Enteral feeding bottles to ensure that none were expired. The Director of	

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F 332	Continued From page 33 A review of the facility's policy and procedures revised on January 2, 2014, titled "Medications Errors," indicated a medication error is defined as a discrepancy between what the physician/mid-level provider ordered and what the patient received. The types of errors include; medication omission; wrong patient, dose, route, rate, or time; incorrect preparation; and/or incorrect administration technique.		dietary staff on 11/6/17 on the Cleaning Schedule policy & procedure and the Dietary Weekly Cleaning Schedule, which includes cleaning and defrosting of the ice cream freezer.	
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (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 from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This Requirement is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the staff tested the low	F 371	**Potential Residents that can be affected:** The Food Service Director, or designee conducted random checks to ensure that the dietary staff are checking the low temperature dishwasher's final rinse PPM hypochlorite on dishware properly. He also conducted random checks of the ice cream freezer to ensure that there were no solid ice adhered to the sides of the ice cream freezer. No deficient practice were identified. **System Change:** The Food Service Director completed an in-service on 11/6/17 to the dietary staff on proper techniques of testing the low temperature dishwasher's final rinse PPM hypochlorite on dishware. He also completed an	

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F 431	Continued From page 36 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the gastric tube feeding bottles were not expired and to date its Lantus insulin vials in one of 2 medication storage areas. This failure had the potential to cause adverse reactions, when administered to residents. Findings:	F 431	Nursing inspected the Insulin vials in both medication storage areas to ensure that they were dated properly. No other deficient practices were identified. **System Change:** The Director of Nursing (DON) in-serviced licensed nurses on 11/29/17 and 11/30/17 on checking the medication room daily to ensure that there no unlabeled insulin vials, which will be completed by 12/7/17. The DON also educated the Central Supply Coordinator on 11/29/17 re: ensuring there are no enteral feeding bottles that are expired are stored. Central Supply Coordinator will conduct enteral supply room weekly inspections to ensure that there are no expired enteral feeding bottles. Any expired enteral feeding bottles will be immediately removed and discarded. The licensed nurses shall check during their shift rounds for any	

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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
F 431	Continued From page 37 During an observation on November 3, 2017 at 5:40 p.m., of the medication supply room at station A with the Director of Nursing (DON), a bottle of Jevity 1.5 cal (liquid feeding for g-tube residents) had an expired date of October 2016. During an interview with the DON on the same date and time, it was stated that bottle should have been disposed. During an observation on the same date at 5:55 p.m. with Registered Nurse 2 (RN 2), in medication supply room at station B, there was an open bottle of Lantus insulin, that did not have an opened or expired date. During an interview with RN 2 on November 3, 2017 at 5:58 p.m., stated the Insulin should be dated when it was opened. RN 2 further stated there was no way to know the expiration date if there the bottle was not dated when opened. A review of the facility's policy and procedures titled "Lantus (insulin glargine injection) solution for subcutaneous injection..." from the website, http://products.sanofi.us/lantus/lantus.html, provided by the facility, indicated the storage, a 10 mL vial is good for 28 days refrigerated or room temperature.	F 431	unlabeled insulin vials and discard any identified. **Monitoring:** The Director of Nursing/RN Supervisors will conduct weekly medication room and medication supply room inspections to ensure that there are no unlabeled insulin vials and no expired enteral feeding bottles. The findings of the medication and central supply room inspections will be reported by the Director of Nursing to the monthly Quality Assurance and Performance Improvement Committee for at least three months. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed. **Completion Date:** December 7, 2017	
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441	**F441 Infection Control** **Immediate Corrective Action:** The Administrator provided 1:1 education with CNA 50 on	

Printed: 11/22/2017
FORM APPROVED
OMB NO. 0938-0391

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	055531	A. BUILDING _____ B. WING _____	11/07/2017

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F 441	Continued From page 38 communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 441	proper Hand Hygiene between resident to resident, changing gloves after shower and peri care, washing hands before touching resident personal items, washing hands before distributing dietary trays on 11/29/17. **Potential Residents that can be affected:** Nurse Practice Educator conducted infection control rounds to ensure that staff are following proper Hand Hygiene between resident to resident, changing gloves in-between care such as after showers and peri care, washing hands before touching resident personal items, washing hands before distributing dietary trays. No other deficient practice was identified. **Process to Prevent Reoccurrence:** Nurse Practice Educator initiated in-services on 11/29/17 to nursing staff on proper Hand Hygiene between resident to	

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F 441	Continued From page 39 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy procedure to prevent spread of infection for one of 6 Randomly Selected Residents (RSR 17) by not following proper hand hygiene between resident to resident, failed to change gloves after shower and peri care, failed to wash hands before touching resident personal items and failed to wash hands before distributing the dietary trays. This deficient practice place the residents at risk for spreading germs to other residents, family and staff members. Findings: a. During an observation on November 6, 2017 of a shower for RSR 17 at 9:30 am, CNA 50 assisting resident with shower and peri care. CNA 50 was observed transporting RSR 17 back to her room by shower chair with same gloves on. CNA 50 was observed touching clean cloths and	F 441	resident, changing gloves in-between care (i.e. after showers and peri care), washing hands before touching resident personal items, washing hands before distributing dietary trays. Competency Validations for Hand Hygiene were also initiated on 11/29/17. Education and competencies will be completed by 12/7/17. The RN Supervisors, or designee will make observations during their daily rounds to ensure that staff are following proper Hand Hygiene between resident to resident, changing gloves in-between care, washing hands before touching resident personal items, washing hands before distributing dietary trays. Findings will be reported to the Director of Nursing for review. Additional in-services will be provided, as needed. **Monitoring:** The outcome of the observations will be reported by the Director of Nursing to the monthly Quality Assurance and	

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F 441	Continued From page 40 bedside table, then took gloves off, placed them on the bedside table, then discarded them in trash. CNA 50 then began to assist by putting on the cloths and continent brief on resident, when assisting resident from shower chair to wheel chair, large bowl movement (BM) was observed on shower chair. CNA 50 wiped the BM off the shower chair with a large dry white towel and used another large white dry towel to wipe resident without washing the hands and putting on a pair of gloves. CNA 50 then placed the towels on shower chair. CNA 50 went the personal belonging bag with hair products, begin to brush and comb the resident's hair. CNA 50 then washed her hands, however begin to transport the dirty linen and dirty shower chair to dirty storage area. Then went to room 38 grabbed a continent brief off 38 b bed and hand to a resident in 38 bed a, then proceeded to room 40 bed c assisting resident to bathroom holding resident hands. CNA 50 did not wash her hands inbetween caring for the residents. CNA 50 also observed rubbing eyes with both hands, then proceeded to pass out dietary trays to residents. During an interview with the Director of Staff Development (DSD) on November 6, 2017 at 11:30 a.m., stated staff should wear gloves when giving a shower. They should change gloves after peri-care and after transporting resident back to room. The shower chairs should be disinfected with santi-cloth before placing chair in dirty storage area. The DSD stated the staff should wash hands before entering room, before touching the residents and wash their hands before passing out dietary trays. The facility's revised policy and procedure titled	F 441	Performance Improvement Committee for at least three months. The committee will evaluate the plan for effectiveness and provide further recommendations, as needed. **Completion Date:** December 7, 2017	

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F 441	Continued From page 41 "Infection control Policies and procedures, Hand Hygiene" dated November 28, 17, indicated to perform hand hygiene: before patient care, before an aseptic procedure (aseptic technique means using practices and procedures to prevent contamination from pathogens), after any contact with blood or other body fluids, even if gloves are worn, after patient care, after contact with the patients environment. Hand hygiene techniques: wash hands with soap and water for 20 seconds covering all surface of the hands and fingers.	F 441		