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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09E020 | A. BUILDING _____ B. WING _____ | 05/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| JEANNE JUGAN RESIDENCE | 4200 HAREWOOD ROAD NE WASHINGTON, DC 20017 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>A recertification Quality Indicator Survey (QIS) was conducted on May 20, 2014 through May 23, 2014. The deficiencies are based on observation, record review, and/or resident and staff interviews for 21 sampled residents.<br><br>Glossary:<br>ARD- Assessment Reference Date<br>MAR-Medication Administration Record<br>MDS-Minimum Data Set<br>QIS-Quality Indicator Survey | F 000 | | |
| F 272<br>SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status; | F 272 | | |

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

Fr. Celestine Meade | Administrator | 6/18/2014

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 272 | Continued >From page 1<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, record review and staff interview for two (2) of 21 sampled residents, it was determined that the facility staff failed to conduct an accurate assessment and standardized reproducible assessment of residents to demonstrate identification of current function capacity on the Minimum Data Set (MDS). Residents' #5 and 25.<br><br>The findings include:<br><br>1. Resident #5 was admitted to the nursing facility on June 19, 2012 with diagnoses which include: Hypertension, Osteoporosis, Degenerative Joint Disease, Hyperlipidemia, Anxiety, Parkinson ' s disease, and Dementia.<br><br>Medical record review on May 22, 2014 at approximately 2:30 PM revealed a Quarterly Minimum Data Set (MDS) with Assessment | F 272 | #1<br>1. Minimum Data Sets for resident #5 was modified to reflect his current functional capacity and transmitted on 6.11.2014. Resident #5 was not observed or reported to have been harmed by this deficient practice.<br>2. MDS Coordinator reviewed all other resident's functional capacity codings on his MDS and the facility is found to be in compliance.<br>3. MDS Coordinator reviewed the RAI Manual ADL section for accurate coding of resident's functional capacity on 5.27.2014. MDS Coordinator in-serviced nursing staff on 6.12.2014 on how to accurately code resident's functional capacity in the POC and in the monthly summary. *(See Appendix A)*<br>4. Resident's functional status will be assessed by MDS Nurse and will be discussed during care conference with the interdepartmental team members which will include a CNA, Restorative Staff and Unit nurse. MDS Nurse will review all CNA documentations and Nurse's monthly summary to ensure that they reflect resident's current functional status. A random check by DON/ADON of the MDS Physical Functioning and Structural Problems section will be done. All findings will be reported to the quarterly QA meeting.<br>5. Corrective action was completed on 6.12.2014. | **6.12.2014** |

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Reference Date of March 5, 2014 with seven (7) - day observation period of February 27, 2014 through March 5, 2014.

In Section G (G0110) - Functional Status, the Minimum Data Set was coded as follows:

A. Transfer - four "(4)"; indicative of total dependence- full staff performance every time during the entire seven (7) day period.

B. Locomotion on unit- four "(4)"; Total dependence-full staff performance every time during the entire seven (7) day period.

C. Eating - four "(4)" - Total dependence- full staff performance every time during the entire seven (7) day period.

Subsequent review of the Nursing Assistant activities of daily living documentation revealed the following documentation for the 7 day observation period February 27, 2014 through March 5, 2014:

Transfer

1. February 27, 2014 10:11 AM Limited Assistance
2. March 2, 20147:07 AMLimited Assistance
3. March 4, 20149:51 AMLimited Assistance
4. March 4, 20148:58 PMLimited Assistance

Locomotion on Unit

1. February 27, 2014 9:53 PMExtensive

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Assistance
2. February 28, 2014 10:15 PM Extensive Assistance
3. March 1, 20149:16 PMSupervision
4. March 2, 20148:07 PMSupervision

Eating

1. February 27, 2014 10:10 AM Extensive Assistance
2. February 27, 2014 9:51 PMExtensive Assistance
3. February 28, 2014 9:53 PMExtensive Assistance
4. March 3, 20142:43 PMLimited Assistance

Further review of the medical record revealed nursing Monthly Summaries for January 27, 2014, February 24, 2014, March 3, 2014, April 7, 2014 and May 5, 2014. The "Functional Status " documentation specified the following information for each aforementioned monthly summaries: transfer- limited assistance; and eating - supervision (exception April 7, 2014 was documented a limited assistance).

In addition, the medical record revealed a physician's order dated February 27, 2014 at 2:30 PM "Restorative Care Program to continue with BUE/LE ' s (bilateral upper extremities/lower extremities) AROM (active range of motion) with up to 2 lb. (two pound) weight; walk to dine with walker with w/c (wheelchair) behind and assist of two to continue.

The residential unit log confirmed Resident #5's participation in the Walk-to-Dine program. The documentation in the clinical record for period

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| F 272 | Continued >From page 4<br>March 2, 2014 through March 5, 2014 revealed the following ambulation distance with two or three person assist with gait belt, walker and wheelchair: March 2, 2014 Breakfast- 50 feet and Lunch- 50 feet; March 3, 2014 Breakfast- 50 feet and Lunch- 50 feet; March 4, 2014 Breakfast- 30 feet, and Lunch- 30 feet; and March 5, 2014 Breakfast 65 feet and Lunch- 50 feet.<br><br>Review of The Restorative Functional Maintenance Program start date: October 7, 2013, and last reviewed on December 19, 2013 revealed "Resident's functional status at discharge from therapy: Bed mobility with minimal assistance; transfers with minimal assist, walks with wheeled walker with close contact guarding with wheelchair follow. " Instructions specified upper and lower extremity active range of motion with up to two (2) pounds and walk to dine with walker with wheelchair follow.<br><br>On May 23, 2014 at approximately 10:30 AM, a face-to-face staff interview was conducted with Employee #9. The nursing assistant documentation, monthly summaries, and restorative nursing notes were reviewed with Employee #9. The surveyor was informed that documentation (activities of daily living coding, monthly summaries, restorative nursing notes) completed by the nursing staff was not accurate. Employee #9 stated, "They don't know how to do the coding ." When surveyor inquired about the resident's participation in the Walk-to-Dine program and restorative nursing documentation, Employee #9 was unable to provide further information.<br><br>On May 22, 2014 at 4:13 PM, Resident #5 was observed ambulating in corridor with wheeled | F 272 | | |

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| F 272 | Continued >From page 5<br>walker and two staff members following behind; one with wheelchair and the other with hand on gait belt. Resident # 5 ' s gait was noted to be steady, and staff provided no weight-bearing support.<br><br>The medical record lacked documented evidence to support the coding of Resident #5 as totally dependent on the Minimum Data Set dated March 5, 2014.<br><br>The facility staff failed to conduct an accurate and reproducible assessment of Resident #5 to demonstrate identification of current function capacity on the Minimum Data Set (MDS).<br><br>The clinical records were reviewed on May 22, 2014.<br><br>2. Resident # 25 was admitted to the nursing facility on January 4, 2010 with diagnoses which include: Anemia, Parkinson's disease, and Dementia.<br><br>Medical record review on May 23, 2013 at approximately 12:30 PM revealed a Quarterly Minimum Data Set (MDS) with Assessment Reference Date of April 10, 2014 with seven (7) day observation period of April 4, 2014 through April 10, 2014.<br><br>In Section G (G0110) - Functional Status, the Minimum Data Set was coded as follows:<br><br>A. Transfer- four "(4)"; indicative of total dependence- full staff performance every time during the entire seven (7) day period.<br>B. Bed mobility- four "(4)"; Total dependence- full | F 272 | #2<br>1. Minimum Data Sets for resident #25 was modified to reflect his current functional capacity and transmitted on 6.11.2014. Resident #25 was not observed or reported to have been harmed by this deficient practice.<br>2. MDS Coordinator reviewed all other resident's functional capacity codings on his MDS and the facility is found to be in compliance.<br>3. MDS Coordinator reviewed the RAI Manual ADL section for accurate coding of resident's functional capacity on 5.27.2014. MDS Coordinator in-serviced nursing staff on 6.12.2014 on how to accurately code resident's functional capacity in the POC and in the monthly summary. *(See Appendix A)*<br>4. Resident's functional status will be assessed by MDS Nurse and will be discussed during care conference with the interdepartmental team members which will include a CNA, Restorative Staff and Unit nurse. MDS Nurse will review all CNA documentations and Nurse's monthly summary to ensure that they reflect resident's current functional status. A random check by DON/ADON of the MDS Physical Functioning and Structural Problems section will be done. All findings will be reported to the quarterly QA meeting.<br>5. Corrective action was completed on 6.12.2014. | **6.12.2014** |

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staff performance every time during the entire seven (7) day period.
C. Dressing- four "(4)"; Total dependence- full staff performance every time during the entire seven (7) day period.

Subsequent review of the Nursing Assistant activities of daily living documentation revealed the following documentation for the 7 day observation period April 4, 2014 through April 10, 2014:

Transfer

1. April 4, 2014 11:11 AM Extensive Assistance
2. April 4, 2014 10:17 PM Extensive Assistance
3. April 5, 2014 10:00 PM Limited Assistance
4. April 6, 2014 9:49 PM Limited Assistance

Bed Mobility

1. April 4, 2014 6:30 AM Extensive Assistance
2. April 4, 2014 10:16 PM Extensive Assistance
3. April 5, 2014 11:09 AM Limited Assistance
4. April 5, 2014 9:59 PM Limited Assistance

Dressing

1. April 4, 2014 11:11 AM Extensive Assistance
2. April 4, 2014 10:16 PM Limited Assistance
3. April 6, 2014 5:02 AM Extensive Assistance
4. April 6, 2014 2:19 PM Extensive Assistance
5. April 6, 2014 9:48 PM Limited Assistance
6. April 8, 2014 11:29 PM Limited Assistance

Further review of the medical record revealed a nursing Monthly Summary for April 9, 2014. The

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| F 272 | Continued >From page 7<br>"Functional Status" documentation specified the following information: transfer- limited assistance; bed mobility - extensive assistance; and dressing- limited assistance.<br><br>On May 23, 2014 at approximately 10:30 AM, a face-to-face staff interview was conducted with Employee # 9. The nursing assistant documentation and monthly summary was reviewed with Employee # 9. The surveyor was informed that documentation completed by the nursing staff was not accurate. Employee #9 stated, " They don't know how to do the coding." When surveyor inquired about the resident's participation in the Walk-to-Dine program and restorative nursing documentation, Employee # 9 was unable to provide further information.<br><br>The medical record lacked documented evidence to support the coding of Resident #25 as "totally dependent" on the Minimum Data Set dated April 10, 2014.<br><br>The facility staff failed to conduct an accurate and reproducible assessment of Resident #25 to demonstrate identification of current function capacity on the Minimum Data Set (MDS).<br><br>The clinical record was reviewed on May 23, 2014. | F 272 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced | F 281 | | |

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| F 281 | Continued >From page 8<br>by:<br>Based on observation and staff interview for one (1) of 21 sampled residents, it was determined that facility staff failed to meet professional standards of quality related to medication administration as evidenced by the registered nurse signing the Medication Administration Record (MAR) prior to administering medication.<br><br>The findings include:<br><br>In accordance with Agency for Healthcare Research Quality, Patient Safety Resource dated May 4, 2014, "Why Medication Administration Errors Occur" stipulates "...Failure to follow policies and procedures results in lack of attention to safeguards intended to prevent errors in medication administration procedures..."<br><br>The facility's policy entitled Medication Administration dated February, 2010 stipulates: "PROCEDURES ...9. Initial each medication in the correct box in the MAR as each medication after administration ...14. Circle initials on MAR if medication is not administered as ordered and record reason on MAR... "<br><br>Resident #29 was admitted to the nursing facility with diagnoses which included Hypertension, Dementia, Depression, Arthritis, and Glaucoma.<br><br>During a staff interview with Employee # 6 on May 21, 2014 at 10:15 AM, Employee #11 entered the room and requested the Medication Administration Record for Resident #29. Employee #11 informed Employee #6 that Resident #29 was experiencing pain. After reviewing the Medication Administration Record, | F 281 | 1. Resident #29 was not observed or reported to have been harmed by this deficient practice. An in-serviced was given to the nurse on 5.22.2014 on the Medication Administration Policy and Procedure.<br>2. No other resident is affected by this deficient practice. Nurses were in-serviced on Medication Administration Policy and Procedure on 6.12.2014.<br>3. All new nurses will be observed on medication pass during orientation and a medication pass observation will be done quarterly on each charge nurse using the Medication Pass Survey tool.<br>4. ADON/DON and QA nurse will do a monthly and random medication pass observation on nurses. All findings will be reported in the quarterly QA meetings.<br>5. Corrective action was completed on 6.12.2014. | **6.12.2014** |

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| F 281 | Continued >From page 9<br>Employee #11 initialed the Medication Administration Record in the space allotted to record the administration of medication [Tylenol]. Employee #11 stated, "I will sign it off now. If [he/she] does not take it, I will come back and circle it... "<br><br>Subsequent review of the Medication Administration Record confirmed that Employee #11 initialed the Medication Administration Record prior to obtaining and administering the medication.. Tylenol 1000 milligrams by mouth was signed as given on May 21, 2014 at 10:15 AM, by Employee #11 prior to its administration.<br><br>A face-to-face interview with Employee #11 was conducted on May 22, 2014 at approximately 3:45 PM. During the interview, Employee #11 confirmed and acknowledged the aforementioned observation.<br><br>The facility staff failed to meet professional standards and the facility's policy related to medication administration.<br><br>The findings were discussed with and acknowledged by Employee#6 and Employee #11 on May 22, 2014 at 3:45 PM. | F 281 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 #1 | 1. The surge protector that was found on the floor in room#1401 was permanently mounted on the wall on 5.26.2014. Resident was not reported or observed to have been harmed by this deficient practice.<br><br>2. All rooms on both units were inspected and they are all in compliance. No other resident is affected by this deficient practice. | |

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| F 323 | Continued >From page 10<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on May 20, 2014 at approximately 3:00 PM, it was determined that the facility failed to maintain resident's areas free of accident hazards as evidenced by a surge protector observed on the floor of one (1) of 19 resident rooms, an extension cord being used in one (1) of one (1) Physical Therapy unit and call bell cords that were wrapped around the grab bar in three (3) of 19 resident's rooms.<br><br>The findings include:<br><br>1. A surge protector was observed in use, on the floor of resident room #1401 and presented a tripping hazard.<br><br>2. An extension cord with three (3) occupied outlets was stored on the floor of the rehabilitation room and presented a tripping hazard.<br><br>3. Call bell cords were wrapped around the grab bar in such a manner as to prevent them from alarming in three (3) of 19 resident rooms surveyed.<br><br>These observations were made in the presence of Employees #4 and #5 who acknowledged the findings. | F 323 | (F 323 #1 Continuation)<br>3. All nursing staff were in-serviced on the proper use of surge protectors on 5.26.2014 and to notify maintenance department for any electrical needs. *(See Appendix D)*<br>4. Unit Supervisor will do a monthly room and unit inspection. Maintenance Department Supervisor and QA nurse will do a random unit and room inspection. All findings will be reported to the monthly Safety and quarterly QA meetings.<br>5. Corrective action will be completed by 6.25.2014.<br><br>#2<br>1. The extension cord with 3 occupied outlets found in the rehabilitation room that is a tripping hazard was replaced with surge protector that was permanently secured and mounted to the wall on 5.26.2014.<br>2. The entire rehabilitation room was inspected and no other cord was found deficient. No resident was observed or reported to have been harmed by this deficient practice.<br>3. An in-service was given to the rehabilitation staff to keep all cords off the floor and to notify maintenance for all electrical needs on 5.26.2014. *(See Appendix D)*<br>4. Rehabilitation Department Supervisor will inspect rehabilitation room monthly. QA nurse and Maintenance Department supervisor will monitor and inspect rehabilitation room randomly. All findings will be reported to the monthly Safety and quarterly QA meetings. | **5.26.2014** |
| F 371 | 483.35(i) FOOD PROCURE, | F 371 | 5. Corrective action was completed on 5.26.2014. | **5.26.2014** |

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| F 371 SS=D | Continued >From page 11<br>STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on May 20, 2014 at approximately 10:00 AM, it was determined that the facility failed to prepare food under sanitary condition as evidenced by two (2) of eight (8) fire suppressors noted with soiled plastic covers.<br><br>The findings include:<br><br>1. Two (2) of eight (8) fire suppression outlet plastic covers were visibly soiled with debris and needed to be cleaned or replaced.<br><br>This observation was made in the presence of Employee #1 and Employee #3 who acknowledged the findings on May 20, 2014. | F 371 | #3<br>1. The call bell cords that were found deficient were immediately corrected on 5.20.2014. No resident was observed or reported to have been harmed by this deficient practice.<br>2. All call bell cords in the residents' rooms were inspected and cut short just enough to freely dangle without touching the floor. All other call bell cords were found in compliance.<br>3. Staffs were in-serviced on 5.26.2014 on keeping call bell cords freely dangling at all times ensuring that they are not wrapped around the grab bars. *(See Appendix D)*<br>4. Unit Supervisor will monitor call bell cords monthly. QA and Maintenance Department Supervisor will randomly check call bell cords and all findings will be reported to monthly Safety and quarterly QA meetings.<br>5. Corrective action was completed on 5.26.2014 | **5.26.2014** |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and | F 514 | 1. The two (2) out of eight (8) fire suppression plastic covers were immediately cleaned and sanitized and free of debris on 5.20. 2014.<br>2. All other fire suppression covers were inspected and all were in compliance.<br>3. All dietary staff were in-serviced on cleaning the Suppression plastic covers on 6.16.2014 which will be done daily as part of the dietary closing checklist. *(See Appendix B)* | |

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|---|---|---|---|
| | 09E020 | A. BUILDING _____ B. WING _____ | 05/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEANNE JUGAN RESIDENCE | 4200 HAREWOOD ROAD NE WASHINGTON, DC 20017 |

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| F 514 | Continued >From page 12<br>systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for two (2) of 21 sampled residents, it was determined the facility staff failed to maintain the clinical record in accordance with accepted professional standards and practices as evidenced by failure to accurately transcribe medication orders and document medication administration in accordance with acceptable professional standards. Residents #28 and 29<br><br>The findings include:<br><br>1. The facility staff failed to accurately transcribe three ophthalmic medication orders on the May 2014 Medication Administration Record (MAR) for Resident #28.<br>A review of the clinical record revealed that Resident #28's diagnoses included Glaucoma.<br>Physician's Order dated May 17, 2014 revealed the following:<br><br>" 5/17/14 Pred Forte 1% one drop 4x daily x 10 days to R [right] eye "<br>"5/17/14 Ketorolac one drop 4x daily x 10 days to R [right] eye"<br>"5/17/14 Vigamox one drop 4x daily x 10 days to R [right] eye" | F 514 | 4. Dietary Supervisors will check and monitor compliance monthly and randomly. All findings will be reported to the monthly Safety and Infection meetings and QA quarterly meeting.<br>5. Corrective action was completed on 6.16.2014.<br><br>1. The physician's ophthalmic orders were clarified and transcribed accurately on 5.21.2014. Resident #28 was not reported or observed to have been harmed by this deficient practice.<br>2. Medication Administration Records were audited and no other resident was affected by this deficient practice.<br>3. New orders are noted, reviewed and transcribed by charge nurses and will make clarifications as necessary. New orders will also be reviewed and audited by the night shift charge nurses which will be included in the 24 hour report. An in-service was given to the nurses on obtaining telephone orders, clarifying orders and accurate transcription of orders on 6.12.2014. *(See Appendix C)*<br>4. ADON/DON and QA nurse will do a monthly and random check of Physician's Orders and Medication Administration Records. All findings will be reported the QA quarterly meetings.<br>5. The corrective action was completed 6.12.2014. | **6.16.2014**<br><br>**6.12.2014** |

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| F 514 | Continued >From page 13<br><br>A review of the May 2014 Medication Administration Record revealed that the transcribed orders lacked the 'route' [eye] of administration as stipulated in the physician's orders as follows:<br>" 5/17/14 Pred Forte 1% one drop 4x daily x 10 days right"<br>"5 /17/14 Ketorolac one drop 4x daily x 10 days right"<br>"5/171/4 Vigamox one drop 4x daily x 10 days right"<br>A face to face interview was conducted on May 21, 2014 at 12:20 PM with Employee #10 and Employee #7. Both acknowledged the aforementioned findings. Facility staff failed to accurately transcribe medications in accordance with physician's orders for Resident #28.<br><br>The clinical record was reviewed May 21, 2014.<br><br>2. Facility staff failed to document the administration of medication in accordance with accepted standards of professional practice.<br><br>In accordance with Agency for Healthcare Research Quality, Patient Safety Resource dated May 4, 2014, "Why medication administration errors occur" stipulates "...Failure to follow policies and procedures results in lack of attention to safegaurds intended to prevent errors in medication administration procedures..."<br><br>The facility's policy entitled, Medication Administration dated February, 2010 stipulates: "PROCEDURES ...9. Initial each medication in the correct box in the MAR as each medication after administration ...14. Circle initials on MAR if | F 514 | | |

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| F 514 | Continued >From page 14<br>medication is not administered as ordered and record reason on MAR... "<br><br>Resident #29 was admitted to the nursing facility with diagnoses which included Hypertension, Dementia, Depression, Arthritis, and Glaucoma.<br><br>During a staff interview with Employee # 6 on May 21, 2014 at 10:15 AM, Employee #11 entered the room and requested the Medication Administration Record for Resident #29. Employee #11 informed Employee #6 that Resident #29 was experiencing pain. After reviewing the Medication Administration Record, Employee #11 initialed the Medication Administration Record in the space allotted to record the administration of medication [Tylenol]. Employee #11 stated, "I will sign it off now. If [he/she] does not take it, I will come back and circle it... "<br><br>Subsequent review of the Medication Administration Record confirmed that Employee #11 initialed the Medication Administration Record prior to obtaining and administering the medication.. Tylenol 1000 milligrams by mouth was signed as given on May 21, 2014 at 10:15 AM, by Employee #11 prior to its administration.<br><br>A face-to-face interview with Employee #11 was conducted on May 22, 2014 at approximately 3:45 PM. During the interview, Employee #11 confirmed and acknowledged the aforementioned observation.<br><br>The facility staff failed to meet professional standards and the facility's policy related to medication administration. | F 514 | | |

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| F 514 | Continued >From page 15<br>The findings were discussed with and acknowledged by Employee#6 and Employee #11 on May 22, 2014 at 3:45 PM. | F 514 | | |