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
	095036	A. BUILDING _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE RESIDENTIAL CARE CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Unique Residential Care Center from March 10, 2016 through March 18, 2016. Survey activities consisted of a review of 40 resident clinical records during Stage 1; and review of 33 sampled residents during Stage 2. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status G-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) EMAR- electronic medication administration record HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Assistant cc - cubic centimeter DMH - Department of Mental Health DWC - Dermal Wound Cleanser	F 000	Unique Residential Care center makes its best efforts to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Laws.	

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

Administrator 4/26/2016

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 000	Continued From page 1 Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth S/he She/he SIC Documented as written	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272		

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F 272	Continued From page 2 functional capacity. 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: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 33 Stage 2 sampled	F 272	1. Resident #42, #87 and #114 MDS assessment were reviewed 2. Audits of residents MDS assessments will be conducted for accurate coding of section L, N and I. A modified MDS will be done if any inaccurate coding is identified. 3. MDS Coordinator will be in-services on MDS coding of section I, N and L by the Zimmet Consultant using the MDS RAI Manual 5/11/16 4. MDS Coordinator or designee will conduct monthly audit of section I, L and N of the MDS and findings will be reported to QA monthly for the next 3 months.	5/11/16 5/11/16 5/11/16 5/11/16

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residents, it was determined that facility staff failed to: accurately code the Minimum Data Set (MDS) under Section L (Dental/Oral Status) for two (2) residents; code the MDS for one (1) resident who had a Urinary Tract Infection (UTI); code one (1) resident's active diagnosis of dementia and code (1) one resident for the use of antipsychotic and diuretic medications. Residents' #42, 87 and114.

The findings include:

1A. A review of Resident #42's History and Physical dated September 14, 2015 revealed that the resident was edentulous.

According to the resident' s annual MDS with an Assessment Reference Date (ARD) of September 21, 2015 it was revealed that Section L0200 (Oral/Dental Status) was not coded for being edentulous.

A face-to-face interview was conducted with Employee #19 at 2:15 PM on March 17, 2016. After reviewing the MDS, the employee acknowledged that the MDS was not coded to accurately reflect the resident's edentulous status. The record was reviewed on March 17, 2016.

1B. A review of Resident #42's Attending examination dated November 6, 2015 revealed a diagnosis of dementia and plans to begin Aricept 10mg to treat.

According the resident's quarterly MDS with an Assessment Reference Date (ARD) of December 21, 2015 it was revealed that Section I - (Active Diagnosis) was not coded for dementia.

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A face-to-face interview was conducted with Employee #19 at 2:15 PM on March 17, 2016. After reviewing the MDS, the employee acknowledged that the MDS was not coded to reflect the resident's diagnosis of dementia. The record was reviewed on March 17, 2016.

2. Facility staff failed to accurately code Resident's #114 quarterly MDS Assessment for antipsychotic and diuretic medications received by the resident during the last seven days since admission.

A Review of the Quarterly MDS assessment with Assessment reference date of January 21, 2016 revealed that in Section N0410: Medication Received, staff coded the number of days medication received as " 7 " indicating that medications Haloperidol and Furosemide were received by Resident #114 during the last 7 days since admission. " Section N0410 stated " Enter " 0 " if medication was not received by the resident during the last 7 days. "

A review of the Physician Order Sheet that was signed and dated on January 2, 2016 revealed Resident #114 was ordered the following antipsychotic and diuretic medications:

" Haloperidol tab 0.5mg, 1 tablet by mouth one time a day as needed for agitation. "
" Furosemide tab 40mg, 1 tablet by mouth one time a day for Heart Failure/Hypertension. "

A review of the Medication Administration Record [MAR] from January 1, 2016 to January 31, 2016 revealed that the boxes allotted for documentation of the antipsychotic [Haloperidol]

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was left blank and the boxes allotted for documentation of the diuretic [Furosemide] medication had the nurse ' s circled initials, both indicating that the resident did not receive the aforementioned medications during the last seven days of the MDS assessment.

A review of the Physician ' s Progress Notes dated December 18, 2016 at 3:00PM read " Patient seen today ... HTN [hypertension] ... medical non-adherence ... Dementia ... looks comfortable, has stable clinical course, noncompliant refusing exam, procedures, labs, medication, poor social interaction, has stable weight ... Plan: HTN [hypertension] stable continue current treatment, Dementia with psychosis progressing .... "

The boxes allotted for documentation of antipsychotic [Haloperidol] and diuretic [Furosemide] medications received were left blank or had the nurse's circled initials indicating that Resident#114 did not receive the aforementioned medications during the last 7 days since admission.

A face-to-face interview was conducted on March 16, 2016 with Employee#29 at approximately 11:50AM. He/she acknowledged the findings. The record was reviewed on March 16, 2016.

3A. Facility staff failed to accurately code a significant change Minimum Data Set (MDS) under Section L (Dental/Oral Status) for Resident #87.

Resident #87 was observed on March 14, 2016 at approximately 10:11 AM. The resident had no teeth in his/her mouth.

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F 272	Continued From page 6 A nutritional assessment dated February 3, 2016 revealed " Other indicator affecting nutritional needs ... yes was checked for dentures: upper/lower and no was checked for own teeth ... " According to the resident ' s significant change MDS dated February 4, 2016 revealed that Section L0200 (Oral/Dental Status) the resident was coded as having no natural teeth or tooth fragments. A face-to-face interview was conducted with Employees # 10 and #29 on March 14, 2016 at approximately 1:00 PM. After reviewing the MDS, the employee acknowledged that the MDS was not coded to accurately reflect the resident ' s edentulous status. Further, stated the resident had dentures, and was not having a problem, that ' s why it was not coded for edentulous. The clinical record was reviewed on March 14, 2016. 3B. Facility staff failed to code a significant change MDS in Section I (Active Diagnoses) for Resident #87 ' s UTI (Urinary Tract Infection). An interim physician ' s order dated January 30, 2016 at 5:15 PM directed; " Bactrim DS [double-strength- used to treat a wide variety of bacterial infections] tab- one (1) po (by mouth) daily [times] five (5) days for UTI. " The Medication Administration Record (MAR) for January and February 2016, revealed Bactrim DS was given daily on January 31- February 4, 2016 at 10 AM. A review of the significant change MDS dated	F 272		

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F 272	Continued From page 7 February 4, 2016 revealed that Section I2300- (Active Diagnoses)-Urinary Tract Infection (UTI) (Last 30 days) was not coded for Resident #87 ' s recent UTI. A face-to-face interview was conducted with Employees #10 and #29 on March 14, 2016 at approximately 1:00 PM. After reviewing the MDS, the employee acknowledged that the MDS was not coded to accurately reflect the resident ' s diagnosis of UTI. The clinical record was reviewed on March 14, 2016.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	1. Resident #87 care plan for medication allergy was initiated with appropriate goal and approached on. Resident #87 care plan for dehydration /fluid maintenance initiation of care plan.3/18/16 2. Audits of residents with allergies and dehydration/fluid maintenance were reviewed to identify other residents that require initiation of care plan. Follow will be completed as indicated. 3. Nurse Managers will be in-serviced on the policy and Procedures on care plan initiation for allergies and dehydration/fluid maintenance. 4. Audits of residents care plans with allergies and dehydration/fluid maintenance will be conducted monthly by, Nurse Manager or designee for the next 3 months to monitor for initiation of care plans. The results of the audit will be reported to QA committee for 3 months to monitor progress towards improvement.	4/19/16 5/11/16 5/11/16 5/11/16

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by:
Based on record review and staff interview for one (1) of 33 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches to address a medication allergy and specific interventions for dehydration/fluid maintenance for Resident #87.

The findings include:

1. Facility staff failed to initiate a care plan with goals and approaches to address a medication allergy.

A physician ' s order sheet and plan of care dated January 5, 2016 revealed, " Allergies: Penicillin " .

The MAR (Medication Administration Records) dated January through February 2016 revealed: " Allergies: Penicillins. "

A review of the clinical record for Resident #87 lacked evidence that a care plan was initiated with goals and approaches to address the specific medication allergy to Penicillin.

A face -to-face interview was conducted with Employee# 10 on March 14, 2016 at approximately 10:00 AM regarding the aforementioned finding. He/she acknowledged the findings. The clinical record was reviewed on March 14, 2016.

2. Facility staff failed to initiate a care plan with measureable goals and specific interventions for dehydration/fluid maintenance for Resident #87.

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F 279	Continued From page 9 A review of the significant change Minimum Data Set (MDS) for Resident #87 with an Assessment Reference Date of February 4, 2016 revealed that the resident was coded as having Pneumonia and a UTI (Urinary Tract Infection). A review of Section V (Care Area Assessment) showed that " Dehydration/Fluid Maintenance " triggered as a care area that would be care planned. A review of the clinical record for Resident #87 lacked evidence that a care plan was initiated with measurable goals and specific interventions to monitor for signs and symptoms of dehydration. A face-to-face interview was conducted with Employee #10 on March 14, 2016 at approximately 10:00 AM regarding the aforementioned finding. He/she acknowledged the finding. The record was reviewed on March 14, 2016.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	1. Resident #222 care plan for fall was reviewed and updated with appropriate goal and approaches. 2. Audits of residents with history of falls were reviewed to identify other residents that require updated fall care plans. Follow up is on going to be completed as indicated. 3. Nurse Managers will be in-services on the policy and procedures on care plan update. Nurse Managers or designee will conduct monthly audits of residents with falls to ensure care plans are updated with new interventions. 4. Audits of residents care plans with falls will be conducted monthly by, Nurse Manager or designee for the next 3 months to monitor for care plans updates. The results of the audit will be reported to QA committee monthly to monitor progress towards improvement.	4/20/16 5/11/16 5/11/16 5/11/16

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F 280	Continued From page 10 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 33 Stage 2 sampled residents, it was determined that facility staff failed to update the care plan with new goals and approaches for Resident #222 who had a fall without injury. The findings include: A review of the nursing notes dated January 21, 2016 at 4:41PM revealed, " ...At 10:15 AM writer was informed that the resident was observed on the floor in sitting position near [his/her] door/ Upon assessment no injury noted, resident confused, unable to say what happened, [he/she] said I was going to wash dishes. [he/she] was helped to bed. Resident complained of pain in [his/her] left knee (6/10) ... " MD [medical doctor] made aware, ordered x ray of bilateral hips and pelvic, left and right knee, finger stick. Neurocheck [Neurological Check] in progress ... " A review of the nursing notes dated January 21, 2016 at 6:10 PM revealed, " Resident alert and oriented s/p [status post] fall this morning about 10:30 AM, no injury noted upon assessment, resident c/o [complained of] left knee pain 6/10 Tylenol 325 mg was administered by the charge nurse, resident couldn ' t verbalize how [he/she] fell but stated, ' I was going to do the dishes. '	F 280		

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F 280	Continued From page 11 Resident has intermittent confusion and Dx [diagnosis] of Dementia. MD [medical doctor] made aware, orders for x ray of bilateral hip & pelvis and both knees and to follow facility protocol ...Re-assessment after 1 hr (hour), no visible injury, pain was 1/10 ... " A review of the care plan problem last updated October 8, 2015 revealed the Problem: " Resident was observed on the floor next to [his/her] room." In addition, facility staff list goals and approaches to address interventions to help the resident from sustaining future falls at this time. However, there was no evidence that facility staff updated the care plan with new goal(s) and approaches after the January 21, 2016 fall to address ways to further help prevent the resident from future falls. A face-to-face interview was conducted on March 17, 2016 at approximately 3:15 PM with Employee #2. He/she reviewed the record and acknowledged the findings. The record was reviewed on March 17, 2016.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview for five (5) of 33 Stage 2 sampled residents, it was determined that facility staff failed to implemenet measures to ensure residents maintain the highest practicable well-being as evidenced by failure to: monitor one (1) resident's pre and post dialysis weight in accordance with physician's orders; act with timeliness on a physician ' s order to obtain a neurology consultation for one (1) resident; clarify physician ' s orders and administer medication as ordered by the physician for one (1) resident and fully assess two (2) residents neurological status post unwitnessed fall. Residents #61, 87, 202, 212 and 222. The findings include: 1. Facility staff failed to monitor one resident's pre and post dialysis weight on days of dialysis for Resident#61on Monday, Wednesday and Friday in accordance with physician's order. A review of the physician ' s orders dated January 2, 2016, February 6, 2016 and March 10, 2016 directed, " Monitor pre and post Dialysis weight on dialysis days; Monday, Wednesday and Fridays." A review of the Medication Administration Record [MAR] for the months of January, February and March 2016 revealed that Resident #61's pre and post dialysis weights were not assessed on the following dialysis treatment days: Weights were not obtained prior to dialysis	F 309	1. Resident #61 pre and post dialysis weights were obtained from dialysis center on 3/18/16. Resident #87 did not have order for neurological consult, #183 neurological appointment was made on 3/23/16 and resident is scheduled to see neurologist on 5/25/16. Resident #202 Rebif was discontinued on 3/14/16 and started on titration schedule. Resident #212 and #222 neurological assessment was done with no adverse effect to resident without the documentation of the total Coma score and Best Motor Response. 2. Review of residents that goes to dialysis were reviewed to identify other residents that require pre and post dialysis weight documentation, residents that require timely follow up of appointment and to check medication instruction for accurate administration on medication as ordered by physician. Follow up will be completed as indicated. 3. The licensed nursing staff will be in serviced on policy and procedures on dialysis with emphasis on pre and post weight documentation, consults process, accurate documentation of the total coma score and Best Motor Response and checking of medications for accurate administration instructions as ordered by physician. 4. Nurse Manager or designee will conduct monthly audit of residents on dialysis for documentation of pre and post weight, consults for timely follow up, accurate documentation of the total coma score, Best Motor Response and medication administration record for accurate dosage of medication and clarification of dosage with physician. The result of the audit will be reported to QA committee monthly to monitor progress towards improvement.	3/18/16 5/11/16 5/11/16 5/11/16 5/11/16

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F 309	Continued From page 13 treatments on the following dates during the 7 AM - 3PM shift: Friday January 1, 2016, Monday February 1, 2016, Monday February 22, 2016, Wednesday February 24, 2016 and Wednesday March 16, 2016. Weights were not obtained following dialysis treatments on the following dates during the 3PM - 11PM shift: Friday January 1, 2016, Monday January 25, 2016 and Wednesday February 10, 2016. A face-to-face interview was conducted with Employees #10 and 30 on March 16, 2016 at approximately 11:40 AM concerning the absence of resident#61 ' s pre and post dialysis weights. They acknowledged the findings. There was no evidence that facility staff consistently monitored resident #61 ' s pre and post dialysis weights in accordance with the physician ' s orders. The record was reviewed on March 16, 2016. 2. Facility staff failed to act with timeliness on an order to follow-up in neurology clinic in three (3) months for Resident # 87. A request for consults form dated November 18, 2015, revealed: " Reason for Request: Neurology follow-up - indication - S/P (Status Post) Acute Right Parietal Ischemic Stroke ... Recommendations: ...Exelon 4.6mg patch daily. F/U (Follow-up) in neurology clinic in three (3) months. An interim physician ' s order dated November 18, 2015 [no time indicated] directed; " Reduce Exelon 4.6mg patch daily (24 hours). F/U (Follow	F 309		

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F 309	Continued From page 14 up) in neurology clinic in 3 months. CMP (Comprehensive Metabolic Panel). " A review of the clinical record lacked evidence that facility staff acted on the physician ' s order to obtain a neurology consult for Resident #87. There was no evidence that the resident had seen neurology or that an appointment was pending. A face-to-face interview was conducted on March 14, 2016 at approximately 1:00 PM with Employee # 9. When queried if the neurology appointment had been scheduled per physician ' s orders prior to the state agency inquiry; he/she stated that the appointment was not scheduled and that he/she would investigate what happened. A neurology appointment was scheduled for May 25, 2016 at 3:00 PM. The clinical record was reviewed on March 14, 2016. 3A. Facility staff failed to administer Rebif (a medication used to treat multiple sclerosis) according to the physician ' s order for Resident #202. Review of an " Annual Assessment " dated March 27, 2015 revealed that Resident #202 was admitted to the facility on April 17, 2014 with diagnoses that included Multiple Sclerosis. A medication administration observation was conducted on March 14, 2016 at approximately 11:00 AM. Employee #16 was observed administering medication to Resident #202. Employee #16 removed a small syringe from the medication refrigerator located on 2 South. He/she proceeded down the hallway with the	F 309		

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F 309	Continued From page 15 syringe and the medication cart to the resident ' s room. Employee #16 held the syringe up to read the label, the label read 0 what medication was being administered ... Employee #16 administered the medication in the syringe via injection into the resident ' s upper right arm. A review the physician ' s order dated March 3, 2016 which directed, " Start Rebif 44 mcg SQ [subcutaneously] 3 times a week for Multiple Sclerosis. " An inspection of the medication refrigerator was conducted on March 14, 2016 at approximately 11:30 AM in the presence of Employee #6 and #16. Observed in the refrigerator was a box labeled Rebif that contained 12 of 12 Rebif 44 mcg syringes, and a second box of Rebif that contained 11 of 12 syringes (five (5) syringes were Rebif 22 mcg, and six (6) syringes were Rebif 8 mcg). After reconciling the observed dosage of Rebif given to the resident by Employee #16, with the physician ' s order and the medication [Rebif] stored in the refrigerator, it was determined that Employee #16 failed to administer Resident #202 the prescribed dose of Rebif. At this time both employees reviewed the physician ' s order, the March 2016 MAR (medication administration record), and the boxes of Rebif located in the medication refrigerator. Both employees acknowledged that the incorrect dose of the medication was given. Facility staff failed to administer medication in accordance with the physician ' s order. The record was reviewed on March 14, 2016.	F 309		

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F 309	Continued From page 16 3B. Facility staff failed to clarify instructions for use with the physician when different dosages of Rebif were received for Resident #202. A review of an " Annual Assessment " dated March 27, 2015 revealed that Resident #202 was admitted to the facility on April 17, 2014 with diagnoses that included Multiple Sclerosis. A review of the physician ' s order dated March 3, 2016 directed, " Start Rebif 44 mcg SQ [subcutaneously] 3 times a week for multiple sclerosis. " A review of the Rebif Medication Guide " Instructions for Use " under Dosage and Administration revealed, " The recommended dose is either 22 mcg [micrograms] or 44mcg injected subcutaneously three times per week ..." Under Dosing Information " The Titration Pack containing [six] 6 doses of 8.8 mcg (0.2 mL milliliters) and [six] 6 doses of 22 mcg (0.5 mL) is available for use during the titration period ... " An inspection of the medication refrigerator was conducted on March 14, 2016 at approximately 11:30 AM in the presence of Employee #6 and #16. Observed in the refrigerator was a box labeled Rebif that contained 12 of 12 Rebif 44 mcg syringes, and a second box of Rebif that contained 11 of 12 syringes (five (5) syringes were Rebif 22 mcg, and six (6) syringes were Rebif 8 mcg). On March 14, 2016 at approximately 11:30 AM a face-to-face interview was conducted with Employee #6, the manager on 2 South, and Employee #16. Both employees reviewed the	F 309		

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F 309	Continued From page 17 order, the MAR (medication administration record), and the boxes of Rebif contained in the medication refrigerator. A nursing note dated March 14, 2016 at 3:52 PM revealed, " Resident went for a Neurology visit on 3/3/2016 ...[he/she] brought an order ...start Rebif for MS [Multiple Sclerosis]. Multiple calls were made to get the medication strength. We were informed that medication can be started at 44 mcg, SQ [subcutaneous], three times a week ...However, when the medication arrived, there was two different dosages... " On March 15, 2016 at approximately 2:15 PM, a face-to-face interview was conducted with Employee #6. He/she stated that when the medication arrived there were two boxes. Employee #6 stated, " I don ' t know why we had both boxes, they [the physician ' s office] didn ' t tell us what to do with them. " Facility staff failed to clarify instructions for use with the physician when different dosages of Rebif were received. The record was reviewed on March 15, 2016. 4. Facility staff failed to fully assess Resident #212 ' s neurological status post fall incident as evidenced by the lack of a cumulative score on the coma scale which aides in determining the level of severity, or lack thereof, of injury. According to the Mayo Clinic the Glasgow Coma Scale " ...helps a doctor ...assess the initial severity of a brain injury by checking a person's ability to follow directions and move their eyes and limbs. The coherence of speech also provides important clues. Abilities are scored	F 309		

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F 309	Continued From page 18	F 309		

numerically in the Glasgow Coma Scale. Higher scores mean less severe injuries. " <http://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/basics/tests-diagnosis/con-20029302>

A review of the nursing notes January 25, 2016 at 4:53 PM revealed, " Writer was informed about 11:15 AM that resident was on the floor near [his/her] bed. Upon my arrival resident was observed sitting on [his/her] right side near [his/her] bed. Resident was unable to say what happened. [He/she] said to writer, ' I need a cup of coffee.' On assessment, no injury noted, denies any pain ... MD (medical doctor) made aware, ordered x ray of bilateral hips and [pelvic] neuro check ... "

A review of the " Interim Order " dated January 25, 2016 at 11:15 AM directed, 1) Neuro check post fall. "

A review of the " Neuro Flow Sheet " revealed that the sheets were initiated on January 25, 2016 and completed on January 25, 2016. It was noted that the section to record the resident's " Best Motor Response " was left blank; and the " Coma Scale " score was not tallied in the designated location at the time that each neurological assessment was completed.

There was no evidence that facility staff fully assessed Resident #212 ' s neurological status under "Best Motor Response," tallied and recorded the total score of the coma scale when each neurological assessment was conducted.

A face-to-face interview was conducted on March 17, 2016 at approximately 3:15 PM with

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F 309	Continued From page 19 Employee #2. He/she reviewed the record and acknowledged the findings. The record was reviewed on March 17, 2016. 5. Facility staff failed to fully assess Resident #222 ' s neurological status post fall incident as evidenced by the lack of a cumulative score on the coma scale which aides in determining the level of severity, or lack thereof, of injury. According to the Mayo Clinic the Glasgow Coma Scale" ...helps a doctor...assess the initial severity of a brain injury by checking a person's ability to follow directions and move their eyes and limbs. The coherence of speech also provides important clues. Abilities are scored numerically in the Glasgow Coma Scale. Higher scores mean less severe injuries. " <http://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/basics/tests-diagnosis/con-20029302> A review of the nursing notes dated January 21, 2016 at 4:41PM revealed, "...At 10:15 AM writer was informed that the resident was observed on the floor in sitting position near [his/her] door/Upon assessment no injury noted, resident confused, unable to say what happened, [he/she] said I was going to wash dishes. [he/she] was helped to bed. Resident complained of pain in [his/her] left knee (6/10) ... MD [medical doctor] made aware, ordered x ray of bilateral hips and pelvic, left and right knee, finger stick. Neurocheck [Neurological Check] in progress ... " A review of the " Neuro Flow Sheet " (the sheet used to record the neurological assessments) revealed that the sheets were initiated on January 21, 2016 and completed on January 23, 2016. It	F 309		

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F 309	Continued From page 20 was noted that the section to record the resident ' s " Best Motor Response " was left blank; and the " Coma Scale " score was not tallied in the designated location at the time that each neurological assessment was completed. There was no evidence that facility staff fully assessed Resident #222 ' s neurological status under " Best Motor Response," tallied and recorded the total score of the coma scale when each neurological assessment was conducted. A face-to-face interview was conducted on March 17, 2016 at approximately 3:15 PM with Employee # 2. He/she reviewed the record and acknowledged the findings. The record was reviewed on March 17, 2016.	F 309	1. Review of resident #42 closed record was conducted. Resident was discharged from facility.	3/25/16
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 33 sampled residents, it was determined that facility staff failed to ensure that necessary treatment and services were provided to promote wound healing, subsequently the	F 314	2. Audits of residents with pressure ulcers were reviewed to identify other residents that require necessary treatment and services to promote wound healing. This included reviewing physician orders, nursing evaluation, Braden scale, nurses notes, treatment administration record, notification of dietitian of new pressure ulcer and skin sheet. Follow up will be completed as indicated. 3. Licensed Nursing Staff and nutritionist will be in-serviced on the Policy and procedure on management of pressure ulcers including checking orders and ensuring timely implementation of cushions as ordered, accurate use of Braden scale to identify resident risk, notification of dietitian/nutritionist of new or reopen pressure ulcers. Nurse Manager will be in serviced on the policy and procedure on documentation of pre and post dialysis weight, consult process and documentation of neurological assessment. 4. Audits of residents physician orders for cushion to ensure timely implementation as ordered, pre and post dialysis weight, consult process for timely follow up and tallied and record of coma score And accurate documentation of Best Motor Response will be conducted monthly by Nurse Manager or designee for the next 3 months to monitor for accuracy. The results of the audit will be reported to monthly to monitor progress towards improvement.	5/11/16 5/11/16 5/11/16

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F 314	Continued From page 21 resident ' s facility acquired pressure ulcer progressed to a Stage 3. Additionally, the resident ' s pressure sore risk was inaccurately assessed. Resident #42 The findings include: According to the " Admission Nursing Evaluation " dated September 11, 2015: " Resident # 42 was 94 years old, wheel chair dependent, dependent for toileting, cognitively impaired, admitted from home. " The evaluation included that the resident was " incontinent of bowel / bladder, was dependent for toileting and wore adult briefs at all times. His/her and skin was moist with no areas of breakdown. " A review of Resident # 42 's September 21, 2015 admission Minimum Data Set [MDS] revealed: In Section C, " Cognitive Patterns, " the resident was coded as moderately cognitively impaired with a score of " 9 " in the Brief Interview for Mental Status. According to the " MDS 3.0 User ' s Manual " page C-14, a score of " 8-12 " suggests that the resident has " moderately impaired " cognitive skills for daily decision making. Section G, " Functional Status, " was coded to reflect the resident required extensive assistance of one (1) person for bed mobility, total dependence of two (2) persons for transfer, total dependence of one (1) person for locomotion, limited assistance for eating and total dependence for toilet use. Item G0400, Functional Limitation and Range of Motion: impairment of lower extremities on one side.	F 314		

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F 314	Continued From page 22 Section H, " Bowel and Bladder " always incontinent of bowels and bladder. Section I, " Active Diagnoses " Hypertension, Osteoarthritis, and Anemia Section M, " Skin Conditions " was coded under M0210, " unhealed pressure ulcer(s) " as "0," indicative that the resident was admitted without pressure ulcers. The successive (quarterly) MDS dated December 21, 2015, revealed under Section M, " Skin Conditions, " M0300 " current number of unhealed pressure ulcers at each stage " was coded as "B1" indicative that Resident #42 developed one (1) Stage 2 pressure ulcer. A review of the resident ' s record revealed that physician progress notes written on September 9, 2015, October 12, 2015 and November 6, 2015 documented that the resident had no pressure sores. A physician ' s order dated December 14, 2015, no time noted, directed: " Roho cushion (when available). " This order was included in the monthly pre-printed orders signed by the physician on January 6, 2016. A review of the Treatment Administration Records (TARs) for December, 2015, revealed that the above cited order was transcribed onto the TAR. There was no evidence that facility staff followed up on the physician ' s order and no evidence that the Roho cushion was obtained when ordered. According to a physician ' s progress note dated December 16, 2015 at 3:00 PM: " Sacral	F 314		

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F 314	Continued From page 23 pressure ulcer, Stage 2, clean, ? [increase] pink tissue, minimal serous drainage, no odor ... " According to a physician ' s progress note dated December 23, 2015, " Sacral pressure ulcer partial thickness fully re-epithelized ... " According to a physician ' s progress notes dated February 10, 2016: " Sacral pressure ulcer re-opened, Stage 2, partial thickness, minimal serous drainage, no odor, peri-wound skin intact ... " There was no evidence that the order for the Roho cushion was transcribed onto the February 2016 pre-printed orders. However, there was no evidence that the physician intended to discontinue the Roho cushion and there was no evidence that the directive [December 14, 2015 order] to obtain the cushion was followed through. According to a physician ' s progress notes dated February 17, 2016 at 2:00 PM: " Sacral pressure ulcer Stage 2 slowly healing, ?pink tissue, minimal serous drainage no odor ... " February 24, 2016 at 6:00 PM: " Sacral pressure ulcer now turned to Stage 3, + [positive] slough, + minimal serous drainage, no odor, + pink tissue ... " March 3, 2016 at 3:00 PM: " Sacral pressure ulcer Stage 3 healing, ?pink tissue, minimal slough, no odor, + slough ... " March 8, 2016 at 2:10 PM: " Has sacral pressure ulcer Stage 3 got worse (larger) + slough, + pink tissue, minimal serous drainage, no odor. Poor oral intake/malnutrition ... "	F 314		

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F 314	Continued From page 24 A physician ' s order dated March 7, 2016, no time noted, directed, " Roho cushion for wheel chair " [a wheel chair pressure relieving cushion]. According to a nurse ' s note date March 8, 2016 at 4:46 PM, " Received Roho cushion from Rehab [rehabilitation] this AM and placed in resident ' s chair ... " A review of " The Braden Scale for Predicting Score Risk " revealed the following: " The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development. Scale- [Low Risk 15-16 Moderate Risk 13-14 High Risk 12 or Less]. " <https://www.nlm.nih.gov/research/umls/sourcereleasedocs/2009AA/LNC_BRADEN/> A review of Resident #42 ' s Braden Scale assessments conducted by facility staff revealed the following: September 11, 2015: Sensory perception (ability to respond meaningfully to pressure related comfort) [4] No impairment Moisture (degree to which skin is exposed to	F 314		

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F 314	Continued From page 25 moisture) [4] Rarely moist Activity (Degree of physical activity) [2] Chairfast Nutrition (Normal food intake) - [3] Adequate Friction and Shear - [2] potential problem Score 15 (15-16 indicates low risk) According to the resident ' s MDS with an assessment reference date of September 11, 2015, the resident was coded as " always incontinent of bowel and bladder " in Section H (See above). This would give the resident a score under " always moist " of " One (1) " and a total score of 12 indicating a high risk for pressure ulcer development. September 21, 2015: Sensory perception: [4] No impairment Moisture: [4] Rarely moist Activity: [2] Chairfast Nutrition: [3] Adequate Friction and Shear: [2] potential problem Score 15 (15-16 indicates low risk) According to the resident ' s MDS with an assessment reference date of September 21, 2015, the resident was coded as " always incontinent of bowel and bladder " in Section H (See above). This would give the resident a score under " always moist " of " One (1) " and a total score of 12 indicating a high risk for pressure ulcer development. Facility staff failed to accurately assess Resident #42 ' s risk for developing a pressure ulcer using the Braden Scale. Subsequently a Stage 3 pressure ulcer developed on the sacrum. A review of the most recent Nutrition assessment	F 314		

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dated, September 22, 2015 revealed "Resident would require 1800/2000 cc (cubic centimeter) fluid a day to maintain the goal of no signs/ symptoms (s/s) of dehydration. The plan was to follow nutrition plan of care.

The "Nutrition " care plan initiated on September 22, 2015 revealed "Approaches: monitor for monthly weights, skin condition, s/s [signs and symptoms] dehydration and food intake records. Goals: no significant changes, 75-100% food intake, no s/s [signs/symptoms] dehydration, maintain good weight status. " The nutrition care plan updated December 30, 2015 revealed, " Approaches: increase assistance with meals as needed continue present plan of care."

There was no evidence of further nutritional assessments or interventions after September 22, 2015. There was no evidence that the dietician reviewed the resident ' s nutritional/hydration status when the resident developed a facility acquired pressure ulcer on December 16, 2015, after the resident ' s sacral wound re-opened on February 10, 2016 or when the pressure ulcer worsened to a Stage 3on February 24, 2016.

Facility staff failed to obtain a pressure relieving cushion as ordered by the physician on December 14, 2015. The cushion was re-ordered on March 7, 2016 and obtained from the rehabilitation depart on March 8, 2016 after the wound had progressed to a Stage 3.

The resident was transferred to a local hospital via emergency medical services [EMS] on March 8, 2016 at 4:00 PM as evidenced by the following physician ' s order: " 3/8/16 at 4PM transfer via

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F 314	Continued From page 27 911 to the nearest ER [emergency room], indication poor oral intake/hypotension. " A face-to-face interview was conducted on March 17, 2016 at approximately 9:30 AM with Employee # 8. He/she acknowledged that the resident was admitted without pressure sores, subsequently developed a Stage 2 which healed and re-opened to advance to a Stage 3. He/ she further stated the pressure relieving device was delayed and other than turning and repositioning no other measures were implemented to relieve pressure. After a review of the medical record, Employee # 8 acknowledged the aforementioned findings. The medical record was reviewed on March 17, 2016.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews for two (2) of 33 Stage 2 sampled residents, it was determined that facility staff failed to provide adequate supervision to ensure safety for one (1) resident who sustained second degree burns to the thighs after spilling coffee that was reheated in the microwave by	F 323	1. Review of resident #99 medical record was conducted. Resident burnt area was treated and area healed as of 3/23/16. Resident was provided with cup holder for his wheelchair on 4/14/16. Review of resident #237 was placed at the nurses station for supervision when she was observed on the floor. Resident #237 care plan was reviewed and corrected. 5/11/16 2. Audit of resident in wheelchairs were reviewed to identify other residents with risk to spill coffee when in wheelchair and resident with fall care plans for updated care plans. Follow up will be completed. 5/11/16 3. Nursing Staff will be in-services on facility policy and procedure not to warm resident coffee but to obtain another cup of coffee from the kitchen as needed and facility policy on monitoring residents with high risk for falls care planning process for accurate revision and updates. 5/11/16 4. Audit of residents in wheelchairs and handling of coffee cups at meal times will be conducted monthly by nurse managers or designee. Audits of residents with falls for accurate monitoring and revisions/update of care plans. The results of the audit will be reported to QA committee monthly for the next 3 months to monitor progress towards improvement. 5/11/16	

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facility staff. Additionally, there was no evidence that the facility had a policy in place to ensure the safe handling of reheated and/or microwaved beverages, such as coffee; staff failed to provide adequate supervision to one (1) resident with a history of repeated falls who sustained a fall with an abrasion injury and staff failed to ensure that the environment was free of potential accident hazards as evidenced by surge protectors that were in-use and unsecured in two (2) of 47 resident rooms observed and a janitor's closet that was accessible to residents and unlocked where hazardous substances were stored on one (1) of eight (8) resident care units. Residents #99 and #237.

The findings include:

1. Facility staff failed to provide adequate supervision to ensure safety for Resident #99 who sustained second degree burns to the legs after spilling coffee that was reheated in the microwave by facility staff. Additionally, there was no evidence that the facility had a policy in place to ensure the safe handling of reheated and/or microwaved beverages, such as coffee.

The microwaves used in the facility include the Sunbeam brand microwave. According to the Sunbeam User ' s manual:

" Microwaved water and other liquids do not always bubble when they reach the boiling point; they can actually get superheated and not bubble at all.

Superheated liquid can bubble up when it is moved or when something like a spoon or tea bag is put into it. To prevent this from happening

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and causing injury, do not heat any liquid for more than 2 minutes per cup.

Before removing the container from the oven, allow the container to stand in the oven for 30 to 40 seconds after the oven has shut off, " <http://www.user-manual.info/426413/microwave-oven/sunbeam/sbmw1109w-bl/4/>, (p.3).

According to the " American Burn Association Scald Injury Prevention Educator ' s Guide " , "Older Adults Older adults, like young children, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Because they have poor microcirculation, heat is removed from burned tissue rather slowly compared to younger adults...

Time and Temperature (temp) Relationship to Serious Burns:

Water Temp Time Required for a 3rd Degree Burn to Occur:

155°F	68°C	1 sec
148°F	64°C	2 sec
140°F	60°C	5 sec
133°F	56°C	15 sec
127°F	52°C	1 min
124°F	52°C	3 min

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F 323	Continued From page 30 120°F 48°C 5 min 100°F 37°C Safe Temperatures for Bathing " "Second-degree burns affect both the outer and underlying layer of skin. They cause pain, redness, swelling, and blistering. They are also called partial thickness burns, " (<https://www.nlm.nih.gov/medlineplus/ency/article/000030.htm>). A face-to-face interview was conducted on March 18, 2016 at approximately 9:00 AM with Resident #99. When queried regarding the burn, the resident stated " I place the coffee cup between my thighs before I go down to smoke and drink my coffee in the morning. "When asked how [he/she] sustained burns to thigh the resident stated, " The coffee fell on it and I don ' t want to answer any more questions." A face-to-face interview was conducted with Resident #99 on March 18, 2016 at 11:12 AM. At this time, he/she explained that [he/she] was in the courtyard on [the morning of] March 17, 2016 and had [his/her] coffee cup was on top of the wall that [he/she] was sitting next to. The resident reached up to get the coffee cup and when [he/she] brought the cup down, the coffee spilled on [his/her] lap. A final face-to-face interview was conducted with Resident #99 on March 18, 2016 at 1:50 PM. The resident further explained that [he/she] takes [his/her] coffee down to the courtyard sometimes and [he/she] took it yesterday [March 17, 2016] "After the nurse warmed it up" for [him/her]. [He/she] said that the nurse offered to carry	F 323		

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[his/her] coffee to the courtyard for [him/her] but [he/she] told [him/her] "No, I can make it. "[He/she] stated, I was smoking, I reached for the coffee cup and when [he/she] brought it down it spilled on [him/her]. " It ' s nobody ' s fault but mine" [he/she] said.

An account of the burn injury sustained by Resident #99 was recorded in the following nurse's entry:

March 17, 2016 at 4:43 PM, " ...at about [9:00 AM] resident reported to writer that, while [he/she] was drinking coffee this morning for breakfast, coffee spilled on [his/her] rt (right) thigh. On assessment blister noted. MD (medical doctor) made aware order give to apply Silvadene cream (an antibacterial cream used on burns) to blister area, writer apply the cream as ordered, Resident refused measurement at this time. No complaint of pain voiced ..." (sic)

According to the "Annual Assessment Form" signed and dated by the physician on December 18, 2015, the Resident ' s diagnoses included ...Schizophrenia, PVD (peripheral vascular disease), and orthostatic hypotension ...Surgical procedures: [status post right below the knee amputation, left above the knee amputation].

According to the quarterly Minimum Data Set (MDS) completed February 28, 2016, Resident #99 required limited assistance of one (1) person for transfers, locomotion on unit and off unit, dressing, eating, toilet use and personal hygiene under Section G (Functional Status). Under Section G0400 (Functional Limitation in Range of Motion) the resident was coded with impairment on both sides of the lower extremities and no

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F 323	Continued From page 32 impairment of the upper extremity (shoulder, elbow, wrist, hand). Resident #99 was observed seated in his/her room on March 18, 2016 at approximately 10:15 AM. He/she was seated in a standard sized wheelchair. There was no evidence that the resident ' s wheelchair was equipped with an apparatus such as a cup holder to safely store the coffee during transit or while seated away from a table. A cup of coffee was on the resident ' s bedside table. The resident agreed to permit facility staff to obtain the temperature of his/her coffee. The coffee was 87 degrees Fahrenheit and according to facility staff, it had been served with the breakfast meal. The temperature of the coffee obtained from stored in the coffee maker/dispenser located in dietary services was 172.1 degrees Fahrenheit at 11:02 AM on March 18, 2016. A face-to-face interview was conducted on March 18, 2016 at 10:40 AM with Employee # 27 Certified Nursing Assistant (CNA), caring for resident. He/she stated, " I was working with [Resident #99]. Breakfast came up and I delivered [his/her] tray. I guess [he/she] went to smoke. Later, I saw [him/her] coming off the elevator. I then assisted [him/her] to the room. [He/she] asked to stop at the charge nurse. We stopped and [he/she] asked to have something for [his/her] leg. I then assisted him to [his/her] room. I wouldn't have known anything about the burn if [he/she] hadn't stop to ask the nurse. I assist [him/her] with care. [He/she] moves from the bed to the wheelchair by [him/herself].	F 323		

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F 323	Continued From page 33 [He/she] likes to eat in [his/her] room and does [his/her] own tray setup. " A face-to-face interview was conducted on March 18, 2016 at 10:45 AM with Employee # 25 charge nurse caring for resident. Employee #25 stated, " [Resident #99] went downstairs and came back upstairs. The CNA/Employee #27 was pushing [him/her] towards me. [He/she] said, let me show you something. [He/she] said I was drinking and the coffee] spilled on my thigh. [He/she] refused for the area to be measured." A face-to-face interview was conducted on March 18, 2016 at 10:50 AM with Employee # 26. He/she stated, "I was on the unit at the time. I called Employee# 8 [a nurse manager covering the 2 North unit]. We both went into the room to assess [him/her]. We looked at the coffee cup and it was empty. Employee # 8 asked [him/her] was it hot when [he/she] got the coffee. The resident replied, " Don't ask me no more [expletive used] questions. " [He/she] declined the treatment and said that [he/she] was not taking [his/her] pants off. Employee #8 interviewed the CNAs to see if anyone warmed [his/her] coffee up. They said "No." They [the CNAs] all wrote statements. [Resident #99] stated, [he/she] is not telling you anything, you are too nosey and [he/she] is tired of people coming to [him/her]." A face-to-face interview was conducted on March 18, 2016 at 2:47 PM with Employee # 1, Administrator and Employee #28, CNA. In response a query to review the facility's policy related to the method that staff use to safely heat beverages in the microwave. They both stated, " If they (the resident) want their coffee warmed up,	F 323		

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we warm it up. " Employee # 1 stated, " Yes, we have microwaves to warm up the residents' food when they ask [for the food to be warmed]. Everyone likes their coffee hot. "

Both employees were queried as to how they measure the temperature of the coffee and/or food being served to the resident that is reheated in the microwave. Employee #28 gave an example of another resident that likes his/her coffee reheated and stated, " [resident's name] will tell you to warm [his/her] coffee for 20 seconds ... " Employee #1 did not respond to the question.

Through interview it was determined that the facility ' s practice is to use the microwave to reheat residents' beverages and food when asked. However, there was no protocol, procedure or policy in place to ensure that beverages reheated via microwave are done so safely as to avoid burn hazards.

Through interview it was determined that Resident #99 transported his/her coffee off of the residential unit and throughout the facility in an uncovered coffee cup placed between his/her thighs, as the resident is a bilateral lower extremity amputee and uses his/her hands to propel the wheelchair. There was no evidence that facility staff assessed the resident's needs to determine if he/she could benefit from an adaptive device such as a cup holder or a covered cup to ensure safe handling of the hot beverage.

There was no evidence that facility staff provided adequate supervision to Resident #99 who moved about the facility with an uncovered cup of

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F 323	Continued From page 35 coffee served at an unknown temperature. The resident alerted staff of the burn injury upon his/her return to the unit from the outside courtyard smoking area, as it was not identified by staff supervising activities in the courtyard. There was no evidence that the facility had a protocol in place to ensure safe heating of hot beverages such as coffee in the microwave. Subsequently, the resident spilled the hot coffee onto him/herself and sustained second degree burns to the thighs. The record was reviewed on March 18, 2016. 2. Facility staff failed to provide adequate supervision for Resident #237 who had a history of repeated falls. The resident sustained a fall with an abrasion injury when he/she was placed at the nurse ' s station in the absence of supervision during the 3rd shift (night time - 11PM - 7AM). Staff responding to a loud noise observed the resident lying on the floor with the wheelchair atop him/her. A review of Resident #287 ' s admission Minimum Data Set (MDS) dated November 16, 2015 under Section I, Active Diagnoses revealed his/her diagnoses included Atrial Fibrillation, Diabetes Mellitus, Arthritis, Alzheimer ' s Disease, Unsteadiness on feet and Dementia; Section G, Functional Status was coded as the resident utilized a wheelchair for mobility, required extensive assistance for transfer between bed and chair/wheelchair, extensive assistance for locomotion and toilet use; G0400, Functional Limitation in Range of Motion was coded as " A2 and B2 " indicative of impairment on both sides of the lower and upper extremities. Section C, Cognitive Patterns revealed the resident was	F 323		

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F 323	Continued From page 36 coded as severely cognitively impaired with a score of " 6 " in the Brief Interview for Mental Status (BIMS). Section E, Behavior was coded as having verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) occurred 4 to 6 days, but less than daily. Section J (Health Conditions) - Resident was coded as having one (1) fall with no injury prior to admission. A review of Resident #237 ' s clinical record revealed the resident sustained four (4) falls without injury during the period of November 2015 through December 2015. A low bed and bedside floor mat was one (1) of the interventions initiated to manage the resident ' s falls. The resident sustained a fifth (5th) fall with an abrasion injury on January 5, 2016. A nurses ' note detailing the fall sustained by Resident #237 on January 5, 2016 read as follows: 01/5/2016 - 7:19 AM- At 5 AM, resident found on the floor by the nursing station lying on her back. AAOX# (Awake, Alert and Oriented [times] three (3). Resident denies hitting [his/her] head and denies pain. PERRLA (Pupils Equal, Round, Reactive to Light and Accommodation) - [bilateral] arm grasp equal in strength to both arms. Resident sustained an abrasion to [his/her] mid back- measured 5 cm x 1.5cm with scant amount of bleeding noted. Areas cleansed??? with normal saline and ice applied. V/S (Vital Signs) - 140/76 (blood pressure) - 78 (pulse), 18 (respirations), Temp- 97.3 and FS (finger stick)-108. Resident assisted [times] 2 (two) from the floor. Resident denies pain. AROM (Active range of motion) WNL to all extremities. [MD	F 323		

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named} and RP (responsible party named) notified. MD ordered x-ray of mid back and bilateral hips. Neuro (neurological) check initiated [times] 72 hours... "

A review of the facility ' s incident report titled, " Incident Report Form " , documented by nursing staff, dated January 5, 2016, [Time of Incident- not indicated- left blank]. Read as follows: " Exact Location of Incident: Other: Nursing Station ... Type of Injury: Abrasion [and] Bruise ... Describe Exactly What Happened (What you saw, who reported the incident, what the resident slid) - At 5:00 AM assigned CNA (Certified Nursing Assistant) reported to writer that resident fell out of the w/c (wheelchair) at the nursing station. Resident observed on the floor lying on [his/her] back. Noted to sustained abrasion/bruise [at] mid back. Helped back to w/c. Ice pak applied to midback. Denies pain. ROM (Range of Motion) to all extremities WNL (within normal limits) ... " SIC

A review of the comprehensive care plan for Resident #237 revealed the interdisciplinary team [IDT] identified falls as a problem with a goal that the resident would be free from injury. The plan was initiated November 4, 2015 and updated November 30, 2015, December 12, 2015 and January 5, 2016. The " falls " care plan included [but was not limited to] the following:

" Problem Start Date - 11/4/2015- Category: Falls- Resident observed on the floor (mat) at bedside. Goal Target Date: 02/4/2016- Resident will remain free from injury. Approach: Avoid use of restraints, Give resident verbal reminders not to ambulate/transfer without assistance, Keep RP (responsible party) updated, Observe frequently

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F 323	Continued From page 38 and place in supervised area when out of bed, Provide resident an environment free of clutter ... " Problem Start Date: 11/30/15- Category- Falls- Resident observed on the floor [floor mat] at bedside. Goal Target Date: 03/01/2016- Resident will remain free from injury ... Problem Start Date: 12/12/2015, Category: Falls- Resident observed on the floor [floor mat] at bedside; Goal Target Date: 03/12/2016- Resident will remain free from injury; Approach: 1:1 monitoring through 12/14/2015 ... " Problem Start Date: 01/5/2016- Category: Falls- Resident observed on the floor at nursing station. Goal Target Date: 4/5/2016- Resident will remain safe and injury free [times] 90 days. Approach: Ensure resident ' s chair equipped with device that monitors rising when OOB (Out of bed). Check for placement and functionality [every] shift. Monitor for pain [every] shift ... Obtain PT/OT (Physical Therapy/Occupational Therapy) consult. - Resident currently on caseload. PT/OT made aware. Pharmacy Consultant to review medications. Follow up with recommendations to MD (Medical Doctor). " Resident #237 sustained a fall without injury on December 27, 2016 (fall not recorded in care plan as others listed above) as recorded in the following nurse's entry: "12/27/2015 2:03 PM, Writer was on the unit to assess [Resident #237] that was observed on the floor mat by [his/her] bed in a sitting position, on assessment [he/she] is alert but confused ...." A face-to-face interview was conducted with	F 323		

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F 323	Continued From page 39 Employee #35 on March 23, 2016 at approximately 9:00 AM. When queried regarding Resident #237's fall on January 5, 2016 at the nurse ' s station; he/she stated, " The resident fell out of the Geri chair. " Further stated, the assigned CNA (Certified Nursing Assistant) reported that, Resident #237 was becoming agitated and was trying to get out of the bed. He/she informed the CNA, to get [him/her] out of the bed and put [him/her] at the nurses ' station. The resident was placed at the nurse ' s station before [CNA] went on break. Employee #35 was asked how often Resident #237 was placed at the nurse ' s station. He/she stated about one (1) to two (2) times a week. A face-to-face interview was conducted with Employee #32 on March 30, 2016 [interview was conducted after survey exit due to employee ' s availability]. at approximately 10:00 AM. He/she acknowledged that the resident was observed lying on the floor at the nurses ' station. " The resident had been restless all night. " When queried, if the resident was observed seated at the nurses ' station unsupervised; Employee #32 stated, I was in another room caring for a resident, when I heard a loud noise. He/she proceeded to the door and went to the nurses ' station. After walking over to the nurses ' station desk, [he/she] looked over the desk and observed Resident #237 face down on the floor and the wheel chair was on top of [him/her]. Further stated; that [he/she] called out for help and there was no staff at the nursing station. The clinical record was reviewed on March 18, 2016. Resident #237 sustained a fall from the wheelchair with an abrasion injury. Through interview, it was determined the resident was	F 323		

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F 323	Continued From page 40 placed at the nurse ' s station when he/she was identified as " restless, agitated and attempting to get out of bed. " The care plan intervention identified by the IDT on November 4, 2015 included, " Observe frequently and place in supervised area when out of bed. " There was no evidence that staff implemented measures to promote safety for Resident #237 who demonstrated restlessness, had a history of repeated falls and was placed at the nurse ' s station without supervision. 3. During observations made during on March 10, 2016 at approximately 10:00 AM and on March 15, 2016 at approximately 11:30 AM, it was determined that the facility failed to ensure that the resident environment remains as free of accident hazards as is possible as evidenced by: surge protectors were in-use and unsecured to the wall in two (2) of 47 resident rooms and an open, accessible janitor ' s closet on one (1) of eight (8) resident care units. A. Two (2) of two (2) surge protectors were observed in use and unsecure on the floor of resident room #215A, one (1) of 47 resident rooms surveyed. B. A surge protector was stored on top of a dresser in room #111, one (1) of 47 resident rooms surveyed. C. The entrance door to the janitor's closet located on 2 South was left completely open for approximately 30 minutes, from 11:55 AM to 12:25 PM on March 16, 2016. Jugs of floor cleaning chemical solutions were accessible to residents, staff and visitors.	F 323		

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F 323	Continued From page 41 These observations were made in the presence of Employee #22 and/or Employee # 23 who acknowledged the findings.	F 323		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 33 Stage 2 sampled residents, it was determined that the physician failed to include in the total plan of care that Resident #222 sustained a fall. The findings include: A review of the nursing notes dated January 21, 2016 at 4:41 PM revealed, " ...At 10:15 AM writer was informed that the resident was observed on the floor in sitting position near [his/her] door/ Upon assessment no injury noted, resident confused, unable to say what happened, [he/she] said I was going to wash dishes. [he/she] was helped to bed. Resident complained of pain in [his/her] left knee (6/10) ... " MD [medical doctor] made aware, ordered x ray of bilateral hips and pelvic, left and right knee, finger stick.	F 386	1. Review of residents #222 was conducted and resident did not have adverse effect. 2. Audits of residents with falls progress note were reviewed to identify other residents progress note that did not reflect documentation on their previous falls. Follow up will be completed as indicated 3.Physicians will be in-services on including residents falls in progress note after resident sustained a fall at the center 4. Audits of physicians progress notes of residents with falls will be conducted monthly by nurse manager or designee for the next 3 months to monitor documentation of resident falls. The results of the audit will be reported to QA committee monthly to monitor progress towards improvement.	5/11/16 5/11/16 5/11/16 5/11/16

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F 386	Continued From page 42 Neurocheck [Neurological Check] in progress. " A review of the nursing notes dated January 21, 2016 at 6:10 PM revealed, " Resident alert and oriented s/p [status post] fall this morning about 10:30 AM, no injury noted upon assessment, resident c/o (complained of) left knee pain 6/10 Tylenol 325 mg was administered by the charge nurse, resident couldn't verbalize how [he/she] fell but stated, ' I was going to do the dishes. ' Resident has intermittent confusion and Dx (diagnosis) of Dementia. MD [medical doctor] made aware, orders for x ray of bilateral hip & pelvis and both knees and to follow facility protocol ...Re-assessment after 1 hr (hour), no visible injury, pain was 1/10 ... " A review of the Interim Orders dated January 21, 2016 at 10:15 AM directed, " 1) Neuro check post fall, 2) x ray of bilateral hips and [pelvic] and [right] and [left] knees for pain... 4) Rehab [rehabilitation] screening ..." A review of the Physician's Progress Notes dated January 27, 2016 at 1:00 PM, approximately 6 days following the resident ' s fall incident, revealed that the physician recorded an assessment of the resident to include the resident's diagnoses, vital signs, weight, etc. and wrote a plan of care specific to the resident. However, there was no evidence that the physician addressed the fall sustained by Resident #22 six days prior, on January 21, 2016. A face-to-face interview was conducted on March 17, 2016 at approximately 3:15 PM with Employee # 2. He/she reviewed the record and acknowledged the findings. The record was	F 386		

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F 386	Continued From page 43 reviewed on March 17, 2016.	F 386		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431	1. Review of medication refrigerator was conducted, Rebif and Vancomycin were removed and discarded per protocol. 2. Audits of medication refrigerator was conducted. No other resident was found to be impacted by this practice. 3. Nursing staff will be in-serviced on reviewing medication label for adequate labeling with resident name and administration instruction before storage in the refrigerator and to make sure expired medications were removed from the refrigerator per facility policy. 4. Audits of medication refrigerator will be conducted monthly for expiration date and adequate labeling. The results of audit will be reported monthly to QA committee for the next 3 months to monitor progress towards improvement.	5/11/16 5/11/16 5/11/16 5/11/16

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F 431	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility staff failed to maintain medications in accordance with currently accepted professional principles as evidenced by: failure to ensure proper labeling of a medication; and medication located in the refrigerator was stored beyond the discard date. The findings include: 1.Facility failed to ensure proper labeling of a medication stored in a medication refrigerator. On March 15, 2016 at approximately 2:10 PM, an observation of the medication refrigerator was conducted with Employee #6 present. At this time one (1) of one (1) box of Rebif (medication for multiple sclerosis) Titration Pack was observed in the 2 South Refrigerator. The box did not have a label that contained the name of the resident, the prescribing physician, and the instructions for administration specific to the resident. Employee #6 stated that he/she called the physician ' s office on March 14, 2016 an obtained a new order for the medication. Employee #6 was then observed discarding the contents of the box [syringes] into the sharps disposal container [used to discard of sharp objects] located on the side of the medication cart. On March 15, 2016 at approximately 2:15 PM a face-to-face interview was conducted with Employee #6 regarding the unlabeled box, he/she acknowledged the findings.	F 431		

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F 431	Continued From page 45 2. Facility staff failed to remove medication from the 1North refrigerator that was stored beyond the discard date. On March 15, 2016 at approximately 10:20 AM one (1) of one (1) bag of Vancomycin (antibiotic) 750 mg (milligrams) in 150 ml (milliliters) of D5W (5% dextrose in water) premix was observed in the 1 North medication refrigerator. The medication contained a label that read " Discard after 12/3/15 " There was no evidence that facility staff removed the 750 mg bag of Vancomycin from the refrigerator after the discard date on 12/3/15. On March 15, 2016 at approximately 10:25 AM a face-to-face interview was conducted with Employee #3. He/she acknowledged the findings.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	1. Employee #24 personnel record was reviewed for administration of PPD. Employee #24 received PPD. 3/17/16 2. Audits of all new hires personnel files were reviewed to identify other residents that require PPD or chest x-ray. Follow up will be completed as indicated. 5/11/16 3. Director of Human Resources and Human Resources Assistant will be in-serviced on facility policy and procedure on administration of PPD on new hires on ensuring chest –x-ray result is obtained on new hires 5/11/16 4. Audit of new hires personnel records will be conducted monthly for provision of PPD or presence of Chest x-ray on new hires. The results of the audit will be reported monthly for the next 3 months to the QA committee to monitor progress towards improvement. 5/11/16	

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F 441	Continued From page 46 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of seven (7) newly hired employee records reviewed, it was determined that facility staff that have direct contact with residents were free of communicable diseases as evidenced by failure to screen Employee #24 for communicable disease prior to or at the time of hire; and facility failed to ensure that eyewash solution was not stored for use beyond the expiration date as evidenced by expired eyewash solution in two (2) of eight (8) janitor ' s closets in the facility. The findings include:	F 441		

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F 441	Continued From page 47 1. Facility staff that have direct contact with residents were free of communicable diseases as evidenced by failure to screen Employee #24 for communicable disease prior to or at the time of hire. A review Employee #24's personnel record revealed that he/she was hired as a Certified Nursing Assistant (CNA) on December 7, 2015. A review of Employee #24's time sheet revealed that he/she worked on the following dates: December 7, 2015 from 8:00 AM to 4:00 PM; December 8, 2015 from 8:00 AM to 4:30 PM; December 16, 2015 from 7:00 AM to 3:00 PM; December 17, 2016 from 7:00 AM to 3:15 PM; December 18, 2015 from 7:00 AM to 3:00 PM; December 26, 2015 from 7:00 AM to 3:15 PM. There was no evidence that facility staff screened Employee #24 for communicable disease prior to or at the time of hire. On March 18, 2016 at approximately 11:15 AM a face-to-face interview was conducted with Employee #18, the Human Resources Specialist with the facility. Employee #18 explained that the process for new employees is that they are supposed to have a PPD prior to starting their employment. Employee #18 acknowledged the aforementioned findings. The record was reviewed on March 17, 2016. 2. Facility failed to ensure that eyewash solution was not stored for use beyond the expiration date as evidenced by expired eyewash solution in two (2) of eight (8) janitor ' s closets in the facility.	F 441		

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F 441	Continued From page 48 During a tour of the environment on March 15, 2016 between 11:30 AM and 4:00 PM, it was observed that: Two (2) of two (2) bottles of eyewash solution located in the janitor's closet on 3 South were expired as of July 2014 and two (2) of two (2) bottles of eyewash solution located in the janitor's closet on 3 North were also expired as of July 2014. These observations were made in the presence of Employee # 22 who acknowledged the findings.	F 441	1. The cited expired solution was immediately replaced. 2. A new QA tool was developed and implemented and all locations with eye wash stations were noted on the tool and each one is checked and verified during the daily facility rounds. 3. Coordinate efforts with the environmental and nursing staff so we could quickly address common issues as stated above. 4. The director of facility operations will monitor and conduct audits and make findings available at the monthly QA meeting.	3/15/16 5/11/16 5/11/16 5/11/16
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on March 10, 2016 at 2:05 PM and on March 15, 2016 at approximately 1:10 PM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by the sanitizing solution from the three compartment sink automatic dispenser failed to test at a minimum of 200 parts per million (PPM) as recommended by the manufacturer on three (3) occasions.	F 456	1. The automatic sanitizing dispenser serviced and repaired by Eco lab Technician. 2. All dietary staff were in-serviced on correct procedures and guidelines to follow in pot-washing area. Additionally, staff instructed to notify manager on duty of any equipment malfunctions. 3. Daily monitoring of pot washing area conducted by food service supervisor. Monitoring will consist of using test strips for 200PPM level. Any non-compliance require re-wash, and full compliance requires initial of supervisor. 4. Director monitors, audits an record findings and reports to the QA committee monthly	3/16/16 3/16/16 On-going On-going

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F 456	Continued From page 49 The findings include: Posted on the wall above the three-compartment sink is the manufacturer ' s ' Preparations and Procedure ' guide on how to effectively set up and use the three-compartment sink. Step 2 of the guide, "Test Sanitizer " instructs the user to " Immerse Test Strip in Solution, hold 10 Sec. " Strength Should Measure 200 PPM. " The sanitizing solution from the three compartment sink automatic dispenser tested at less than 200 parts per million (PPM) when tested on March 10, 2016 at approximately 2:05 PM. Employee #20 and Employee #21 drained the solution from the sanitizing sink and refilled it with fresh, sanitizing solution which then tested at 200 PPM as recommended by the manufacturer. The sanitizing solution from the three compartment sink automatic dispenser tested at less than 200 parts per million (PPM) when tested on March 15, 2016 at approximately 1:10 PM. Employee #20 and Employee #21 drained the solution from the sanitizing sink and refilled it with fresh, sanitizing solution which again tested at less than 200 PPM. After adjusting the fill line to the sanitizing solution automatic dispenser, Employee #20 and Employee # 21 again drained the sanitizing sink and refilled it. The sanitizing solution then tested at 200 PPM. These observations were made in the presence of Employee #20 who acknowledged the findings.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

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F 463	Continued From page 50 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on March 14, 2016 at approximately 10:25 AM, it was determined that the facility failed to maintain call bells in good working condition as evidenced by a non-functioning, frayed call bell in one (1) of 47 resident rooms. The findings include: The call bell in room #112 (A) was frayed and did not emit an alarm when tested, one (1) of 47 resident's rooms surveyed. This observation was made in the presence of Employee #4 who acknowledged the finding.	F 463	1. The cited call bell was immediately replaced after it was Discovered corrected 2. The daily room inspection form is monitored, checked and audited by the director and assistant director of facilities daily. 3. Coordinate efforts with the environment and nursing staff so we could quickly address common issues as stated above. The nursing staff were also in-services and instructed to the proper placement of the call bells prior to moving the resident's bed to minimize/prevent re-occurrence. 4. The director of facility operations will monitor and conduct daily audits and report findings to the monthly QA meeting.	3/14/16 5/11/16 5/11/16 5/11/16
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 systematically organized. 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;	F 514		

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	095036	A. BUILDING _____ B. WING _____	03/18/2016

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F 514	Continued From page 51 and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for three (3) of 33 Stage 2 sampled residents, it was determined that facility staff failed to: ensure that two (2) of eight (8) glucometers [a medical device for measuring blood glucose] were set with the current date(s) and time; failed to document behaviors exhibited by one (1) resident on the designated flow sheet; document the administration of pain medication and antipsychotic medication on the Medication Administration Record (MAR) for one (1) resident and document the dosage and the correct route of an experimental drug being administered to one (1) resident. Residents' #114, 183 and 194. The findings include: 1. Facility staff failed to ensure that two (2) of eight (8) glucometers [a medical device for measuring blood glucose] were set to display the current date(s) and time. An observation of two (2) of eight (8) glucometers for the entire building revealed that the current date and time was not set on the devices/machines; and the dates and times of the blood glucose results registered in the device did not reconcile with the dates and times recorded in the medication administration record for the respective resident(s). An observation of the 3 North Glucometer was conducted on March 14, 2016 at approximately 11:40 AM with Employee #17. He/she verified that	F 514	1. Review of glucometers were conducted and glucometers were corrected with current date. Review of resident #114 MAR was conducted for administration of Haldol and Tramadol. Unable to retrospectively correct. Review of resident #183 behavior flow sheet was conducted. Unable to retrospectively correct. Review of resident #194 Harvoni route of administration and dosage was conducted. Route of administration was corrected to reflect via gastronomy tube on 3/1/16 2. Audit of all residents on gastrostomy tube were reviewed to identify other residents with inaccurate route of administration, glucometer for current date, behavior flow sheet for accurate documentation and physician note reflecting previous falls. Follow-up will be completed. 3. Licensed Nursing staff will be in-services on facility policy and procedure on gastrostomy, accurate writing and transcription of orders/review of glucometers for current date, administration/ documentation of medication and accurate documentation of exact behavior on flow sheet by and physician note reflecting previous falls. 4. Audit of residents behavior flow sheets, glucometer for current dates. MAR for accurate administration of medications including dosage will be conducted monthly for the next 3 months. The results of the audit will be reported to QA committee monthly to monitor progress towards improvement.	3/7/16 5/11/16 5/11/16 5/11/16

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F 514	Continued From page 52	F 514		

the glucometer was calibrated incorrectly, and stated he/she would locate the manual to find out how to set the glucometer to the proper date and time.

An observation of the 1 South Glucometer was conducted on March 15, 2016 at approximately 11:25 AM with Employee #14. He/she verified that the glucometer was calibrated incorrectly.

A face-to-face interview was conducted with Employee #4, Unit Manager for 1 South on March 15, 2016 at approximately 3:10PM. He/she acknowledged findings.

A face-to-face interview was conducted on March 16, 2016 at approximately 3:00 PM with Employee #7, Unit Manager for 3 North. He/she acknowledged the findings.

There was no evidence that facility staff ensured that the correct dates and times were set to display on the glucometers.

2. Facility staff failed to document on Medication Administration Record (MAR) that Resident #114 received pain medication and Antipsychotic medication.

A review of the RN (registered nurse) Progress Note dated January 29, 2016 at 8:06AM read, " Alert and verbally responsive, complain of pain on left leg and was medicated with Tramadol 1 tablet. After few hours, resident started again to shout for pain and was helped with massage and talking but no relief. At 6:30AM another Tramadol [non-narcotic pain medication] was given with Haldol [antipsychotic medication] for agitation as ordered. At 7:30 AM resident was observed

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F 514	Continued From page 53 deeply asleep and breathing with no difficulty. " A review of Physician's order signed and dated January 2, 2016 revealed the following PRN (as needed) order: "Haloperidol Tab 0.5mg[milligrams] Administer 1 tablet by mouth one time a day as needed for agitation" and "Tramadol 50mg 1 tab po [by mouth] q [every] 6hr [hours] PRN " A review of the MAR dated January 2016 revealed that the box allotted for the nurse to initial Haloperidol and Tramadol were administered on January 29, 2016 at 6:30 AM was left blank indicating that the medication was not given. Facility staff failed to document that Haloperidol and Tramadol were given on January 29, 2016 at 6:30AM, as documented in the Nurse ' s Progress Note. A face-to-face interview was conducted with Employee #25 on March 14, 2016 at approximately 11:25AM. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. The record was reviewed March 14, 2016. 3. Facility staff failed to document Resident #183 ' s agitated behaviors on the psychoactive monitoring flow sheet. The Physician ' s Order dated March 9, 2016 directed, " Resident to be put in bed after lunch [and] up for dinner. Document resident ' s behavior/reaction when in after bed. "	F 514		

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F 514	Continued From page 54 A review of the electronic resident progress notes revealed the following: " 3/2/2016 at 9:53 AM- Resident was observed attempting to crawl down from the bed ..." 3/4/2016 at 9:20 PM - "...Resident placed near nurse ' s station for observation and administered Ativan 1mg po (by mouth) due to agitation ..." 3/8/2016 at 3:40 PM- "Resident was put back to bed after lunch meal as per order, bed at the lowest level position .... But resident attempted [times] 4 to climb out of bed ..." 3/9/2016 at 3:40 PM- "... Resident got agitated when [he/she] was put to bed after lunch ..." 3/9/2016 at 9:17 AM- "Resident was put back to bed after lunch meal as per order, bed at the lowest position, call bell placed within reach, but resident attempted [times] 4 to climb out of bed... " A review of the " Psychoactive Medication Monthly Flow Record " for March 2016 revealed that the form was coded to document episodes of agitation. There was no evidence of documentation of behaviors exhibited by Resident #183 on March 2, 4, 8 and 9, 2016. A face-to-face interview was conducted with Employee #9 on March 15, 2016 at approximately 5:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on March 15, 2016. 6. Facility staff failed to accurately document the dosage and the correct route of an experimental	F 514		

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F 514	Continued From page 55 drug being administered to Resident #194. A physician ' s annual assessment dated February 27, 2016 revealed Resident #194 ' s diagnoses included: Dementia and Chronic Hepatitis C. The correspondence dated February 11, 2016 at 12:14 from the [Transplant Institute] revealed; " ... Please administer Harvoni 90/400mg (antiviral medication that prevents hepatitis C virus from multiplying in your body) - 1 tablet by mouth daily with or without food. It is important that the medication must be taken at the same time daily ... " The " Physician ' s Order " dated March 11, 2016 directed: " Enteral Feeding Orders: Due to Hep C (hepatits C), Dysphagia ... Tube feeding with Jevity 1.5, 60 ml (Milliliters) via G-Tube (Gastrostomy tube) via pump for 18 hours per day ... " An interim physician order dated February 17, 2016 at 6:00 PM directed: " Harvoni - take one (1) tablet by mouth every day with or without food for Hepatitis C " [times] 12 weeks. An interim physician ' s order dated March 1, 2016 at 11:45 AM directed: " D/C (Discontinue) previous Harvoni medication order, Start Harvoni, one tablet via G-tube daily, with or without foods, for Hepatitis " C " [times] 12 weeks. " A review of the Medication Administration Record (MAR) for February 2016 revealed: nurses initials were in the allotted spaces which indicates that Harvoni - 1 tab was administered on February 16-29, 2016 by mouth every day at	F 514		

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F 514	Continued From page 56 7PM. A face-to-face interview was conducted with Employee #10 on March 14, 2016 at approximately 5:15 PM regarding the aforementioned findings. He /she stated that the resident received the medication via his/her gastrostomy tube. The clinical record was reviewed on March 14, 2016.	F 514		