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	355087	A. BUILDING _____ B. WING _____	11/21/2019

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 11/18/19 and concluded 11/21/19.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		12/26/19

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

Electronically Signed | 12/19/2019

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/18/18. Based on observation and review of facility policy, the facility failed to provide care for 6 of 23 sampled residents (Resident #8, #11, #13, #16, #25, and #35) in a manner/environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to respect residents' personal preferences and knock on doors and wait for a reply prior to entering residents' rooms does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the facility policy titled, "OBRA-Required Actions to Promote Dignity and Privacy" occurred on 11/21/19. This undated policy, stated, ". . . Knock on the door before entering. Wait to be asked in. . . ." - Observations on 11/18/19 showed the following: * At 3:03 p.m., after providing Resident #11's toileting cares, a certified nursing assistant (CNA) (#1) exited the room with a mechanical stand lift. A few minutes later, the CNA (#1) knocked on the	F 550	To ensure corrective action for Residents #8, #11, #13, #16, #25 and #35 (Resident expired), and any other resident that may be affected by failure to respect residents' personal preferences and knock on doors and wait for a reply prior to entering the residents' rooms: staff were re-educated at the Nurse's meeting on 12/12/19 and at the monthly All Staff Meeting on 12/17/19 on knocking on residents' doors, asking permission to enter and waiting for a reply before entering. For residents not able to reply or with a hearing deficit, staff will knock and announce one's presence while slowly entering the room, announce their presence, and explain why they are there. Door knocking signs have been placed near resident doors and in CNA documentation books to remind staff to knock, wait for resident response and permission to enter, announce their presence, and repeat as needed. Staff not present at the meeting will be educated by 12/26/19. To ensure deficient practice will not recur, QA monitoring will be completed by QA Nurse or assigned designee on resident #8, #11, #13, #16, #25 and a random	

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F 550	Continued From page 2 door as she re-entered Resident #11's room. * At 3:15 p.m., a CNA (#1) knocked on the door as she entered Resident #25's room, and stated, "You okay [Resident #25]?" * At 3:17 p.m., a CNA (#1) knocked on the door as she entered Resident #16's room, and stated, "Hey, you ok?" * At 4:43 p.m., a CNA (#12) entered Resident #35's room without knocking, looked at the surveyor, stated, "Oh," turned around and exited the room. - Observations on 11/20/19 showed the following: * At 10:58 a.m., while staff nurse (#10) performed Resident #8's foot dressing change, a CNA (#12) knocked on the door as she entered the room. * At 11:12 a.m., while CNA (#2) provided Resident #13's cares, an unidentified CNA knocked on the door as she entered the room, stated, "Oh, you got it," and exited the room. * At 11:22 a.m., while CNA (#3) provided Resident #13's cares, a CNA (#2) knocked on the door as she entered the room, noticed the CNA (#3) already providing care, and exited the room. The facility staff failed to knock/announce themselves and wait for a reply prior to entering the resident rooms.	F 550	sample of 20% of the resident population weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year to ensure correction is achieved and sustained. The QA Nurse or Designee will report finding to the QA Committee monthly. Any deficient practice will be reported to Administrator and will be immediately corrected.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		12/25/19

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F 656	Continued From page 3 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to develop a comprehensive care plans for residents 5 of 23	F 656	To ensure the facility develops a comprehensive care plan for Resident #9, #11, #13, #31 and #36 and any other	

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F 656	Continued From page 4 sampled residents (Resident # 9, #11, #13, #31 and #36). Care planning drives the type of care/services a resident receives and failure to develop a care plan that includes the care/services to be provided to the resident may negatively impact their quality of life. Findings include: Review of the policy titled "COMPREHENSIVE PERSON CENTERED CARE PLANNING POLICY" occurred on 11/21/19. This undated policy, stated, ". . . The facility shall center care plan on the resident's needs including measurable objectives and time frames. . . ." - Review of Resident #9's medical record occurred on all days of survey. The current physician's orders identified Resident #9 receives Furosemide (a diuretic). The care plan failed to reflect the signs/symptoms of edema/fluid retention, possible side effects of the medication, and/or other interventions. - Review of Resident #11's medical record occurred on all days of survey. The record identified a diagnosis of edema. The current physician's orders identified Resident #11 receives Lasix (a diuretic). The care plan failed to reflect the signs/symptoms of edema/fluid retention, possible side effects of the medication, and/or other interventions. - Review of Resident #13's medical record occurred on all days of survey. The record identified a diagnosis of chronic atrial fibrillation and hypertension. The current physician's orders identified Resident #13 receives Xarelto (an	F 656	resident that may be affected: The facility re-educated the licensed nurses on 12/12/19 during their Nurse's Meeting and the Interdisciplinary Care Plan Team on the development of a comprehensive care plan during a care plan training session on 12/17/19. The care plan (CP) for Resident #9 was updated on 12/17/19 to reflect the use of the diuretic Lasix signs/symptoms of edema/fluid retention, possible side effects of medication, and any other interventions identified. The CP for Resident #11 was updated 12/17/19 to reflect use of Lasix and signs/symptoms of edema/fluid retention, possible side effects of the medication and any other interventions identified. The CP for Resident #13 was updated 12/17/19 to reflect the diagnosis of chronic atrial fib and hypertension. Care Plan for Resident #13 was also updated to reflect the use of Xarelto (an anticoagulant) and signs/symptoms of an adverse reaction to anticoagulant/anti-platelet drug use. CP for Resident #31 was updated on 12/17/19 to reflect diagnosis of urinary incontinence with skin breakdown and identify the problem/need, goal, target date, approaches/interventions necessary skin care needs, and breakdown prevention per physician orders.	

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F 656	Continued From page 5 anticoagulant). The care plan failed to reflect the signs/symptoms of an adverse reaction secondary to anti-coagulant/anti-platelet drug use. - Review of Resident #31's medical record occurred on all days of survey. The record identified a diagnosis of urinary incontinence with skin breakdown. The current physician's orders identified Resident #31 receives a Mepilex dressing topically for skin protection to coccyx every 3 days. The care plan failed to identify the problem/need, goal, target date, approaches/interventions, necessary skin care needs, and breakdown prevention per physician orders. - Review of Resident #36's medical record occurred on all days of survey. The record identified a diagnosis of dementia with behaviors and adjustment disorder with mixed anxiety/depression. The current physician's orders identified Resident #36 receives Zoloft (an antidepressant). The care plan failed to reflect the signs/symptoms of depression, possible side effects of the medication, and/or other interventions.	F 656	CP for Resident #36 was updated on 12/17/19 to reflect the diagnosis of dementia with behaviors and adjustment disorder with mixed anxiety/depression the use of the antidepressant Zoloft, the signs/symptoms of the other medications and other interventions as indicated. All other resident CP's are reviewed/updated upon admission, quarterly, annually and with any significant change by the Interdisciplinary Care Plan Team. Administrator/RN Designee will complete QA monitoring to ensure comprehensive care plans are developed weekly X 1 month, monthly X 3 months, and quarterly thereafter x 1 year on Resident #9, Resident #11, Resident #13, Resident #31 and Resident #36 and a random sample of residents. Administrator/RN will report the results of the QA audit to the monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and will be immediately corrected.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		12/26/19

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F 657	Continued From page 6 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to review/revise care plans to reflect the residents' current status for 3 of 23 sampled residents (Resident #12, #23, and #36). Failure to review/revise care plans to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care for the residents. Findings include: Review of the policy titled "COMPREHENSIVE PERSON CENTERED CARE PLANNING POLICY" occurred on 11/21/19. This undated policy, stated, ". . . The facility shall center care plan on the resident's needs including measurable objectives and time frames. . . ."	F 657	To ensure the facility reviews/revises care plans to reflect the current status for Resident #12, Resident #23, and Resident #36; an inservice was completed on care plans with the nurses on 12/12/17 and the Interdisciplinary Care Plan Team on 12/17/19 on the importance of updating care plans to reflect current status and completing in a timely manner. Care Plans were updated on Resident #12, Resident #23, and resident #36 to reflect their current status. Care Plans for any other residents will be reviewed and updated to reflect their current status upon admission, quarterly, annually, and with any significant change.	

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F 657	Continued From page 7 - Review of Resident #12's medical record occurred on all days of survey. The record identified a diagnosis of anxiety and psychosis. The current physician's orders identified Resident #12 receives Lorazepam (an antianxiety medication), Risperdal (an antipsychotic), and Seroquel (an antipsychotic). Resident #12's care plan identified "Anxiety . . . Observe for change in mental status or any hallucinations . . . Daily routine established . . . Provide opportunity for me to vent . . . Assure me frequently that you will help me with ADLs [activities of daily living] . . . Potential for drug toxicity . . . for antipsychotic med [medication] . . . Observe for increased tremors, or hallucinations . . . Sudafed given daily to decrease oral secretions . . . Evaluate effectiveness and side effects of medication . . ." The care plan failed to reflect the signs/symptoms of anxiety and/or the possible side effects of the antianxiety medication. - Review of Resident #23's medical record occurred on all days of survey. The record identified a diagnosis of anxiety and major depressive disorder. The current physician's orders identified Resident #23 receives Buspar (an antianxiety), Cymbalta (an antidepressant), and Valium (an antianxiety). Resident #23's care plan identified ". . . I may have hallucinations . . . Episodes of crying . . . Calmly talk with me and offer reassurance when I am crying or afraid . . . Try a diversion . . . Monitor and document for any hallucinations . . . Anxiety . . ." The care plan failed to reflect the signs/symptoms of anxiety and/or possible side	F 657	Administrator/RN Designee will complete QA monitoring on Resident #12, #23, #36 and a random sample of residents to ensure comprehensive care plans are revised in a timely manner to reflect their current status weekly X 1 month, monthly X 3 months, quarterly X 3 months and thereafter X 1 year. Administrator/RN Designee will report the results of the QA audit to the monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and immediately corrected.	

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F 657	Continued From page 8	F 657		

effects of the antianxiety and antidepressant medications.

Review of Resident #23's dietary progress notes, dated September 30-October 3, 2019, identified, ". . . recommended small frequent meals/snacks . . . encourage to consume a snack after her exercises . . . likes to have a staff member sit with her at meals which helps encourage her intakes . . ." Resident #23's care plan identified, "Potential for weight loss . . . Food preferences . . . dislikes . . . Best meal of day is breakfast . . . tended to skip noon meal . . . Encourage resident to dine in dining room . . . Able to eat independently after set-up . . . Provide assistance as needed . . . Monitor food intake at each meal and record . . . [Breakfast supplement] . . ."

The care plan failed to reflect Resident #23's need for small meals, frequent snacks, snacks after exercise, and staff encouragement/assistance required during meals.

Review of Resident #23's fall incident reports, dated July 14-August 13, 2019, identified managerial staff recommended Resident #23 wear gripper socks. Resident #23's care plan identified, ". . . Keep call light within my reach . . . Assist me to keep [glasses] on . . . Keep walker close to me so I will remember to use it . . . I use a side rail to assist with repositioning and stability for transfers . . . Maintain environmental free of clutter . . . Place items frequently used within easy reach . . ."

The care plan failed to reflect Resident #23's need for gripper socks.

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F 657	Continued From page 9 - Review of Resident #36's medical record occurred on all days of survey. The record identified a diagnosis of dementia with behaviors and adjustment disorder with mixed anxiety/depression. The current physician's orders identified Resident #36 receives Seroquel (an antipsychotic). Resident #36's care plan identified the "potential for drug toxicity related to Seroquel use," but failed to reflect the signs/symptoms of psychosis/behaviors Resident #36 presents with and failed to reflect possible side effects of the medication and/or other interventions.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Medication Administration Based on observation, review of professional reference, facility policy and staff interview, the facility failed to follow professional standards of practice for 2 of 8 residents (Resident #10 and #24) observed during medication administration. Failure to properly prepare medications may place residents at risk for medication errors. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists,	F 658	To ensure professional standards are followed for Resident #10, Resident #24, Resident #31 and any resident in the facility to have their medications prepared properly and physician orders are followed with wound care; education was provided to the nurses/Med Techs on 12/12/19 during their nursing meeting or at the monthly all staff meeting on 12/17/19. Any nurses/Med Tech's not in attendance will receive the education when they return to work. Education included that medications are administered at the time they are	12/26/19

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F 658	Continued From page 10 page 148 states, ". . . . Medications should be prepared for the resident immediately before administration; medications should never be prepared in advance for multiple residents . . ." Review of the facility policy titled "Medication Administration-General Guidelines" occurred on 11/20/19. This policy, revised April 2014, stated, ". . . Medications are administered at the time they are prepared . . . medications are not pre-poured/prepared . . ." residents . . ." - Observation of medication administration on 11/20/19 at 4:26 p.m., showed an unlabeled medication cup containing five medications in the top drawer of the medication cart. A medication assistant (MA) (#9) confirmed she placed the medication for Resident #10 in the unlabeled container in the drawer. - Observation on 11/21/19 at 8:00 a.m., showed an unlabeled medication cup containing four medications in the top drawer of the medication cart. A staff nurse (#8) stated she attempted to pass medications to Resident #24, the resident refused, and the nurse continued to pass medications to other residents. During an interview on 11/21/19 at 9:23 a.m., administrative nurses (#6 and #7) confirmed they expected staff to follow professional standards regarding medication administration. 2. Dressing changes Based on observation, record review, professional reference and staff interview, the	F 658	prepared. Medications are not to be pre-poured. Education was completed at the nurse's meeting to follow physician orders regarding wound care. A wound care presentation was completed by the facility Consulting Wound Care Clinician at the nurses meeting on 12/12/19. A handout on Dressing Change Guidelines was distributed and reviewed with nurses that included instruction on treatment verification to confirm most current treatment and to follow physician order for each individual resident. Any nurse not at the nurse's meeting on 12/12/19 will be receiving this on their next scheduled workday. To ensure professional standards are followed with medication monitoring and follow physician orders for wound care on Resident #10, #24, #31 and a random sample of 20% of residents in facility. QA monitoring of proper medication administration and dressing changes are completed as per physician order will occur by DON/Designee weekly X 1 month, monthly X 3 months, quarterly thereafter X 1 year. DON or Designee will report the results of the QA audit to the monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and immediately corrected.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 11 facility failed to follow professional standards for 1 of 3 sampled residents (Resident #31) with physician orders for a wound dressing. Finding include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston Massachusetts, page 68, states, "Nurses are expected to analyze procedures and medications ordered by the physician . . . It is the nurse's responsibility to seek clarification . . . the nurse is responsible for carrying it out . . ." Observation on 11/19/19 at 2:27 p.m. showed a staff nurse (#10) performed a dressing change on Resident #31's coccyx area. The nurse (#10) removed a duoderm dressing with a date of 11/16/19. Review of Resident #31's medical record occurred on all days of survey. Physician's orders, dated 11/10/19 read, ". . . Mepilex dressing topically for protection only to coccyx every 3 days . . . change mepilex dressing as needed for protection . . ." Staff failed to carry out the dressing change as ordered by the physician. During an interview on the afternoon of 11/21/19, a supervisory nursing staff member (#7) confirmed she expected staff to follow physician's orders.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		12/26/19

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	355087	A. BUILDING _____ B. WING _____	11/21/2019

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F 689	Continued From page 12 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/18/18. Based on observation, record review, and staff interview, the facility failed to provide adequate assistance for 2 of 5 sampled residents (Residents #9 and #11) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift placed Resident #9 and #11 at risk of experiencing pain/discomfort and/or possible accidents with/without injury. Findings include: - Review of Resident #9's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 09/03/19, identified extensive assistance is required for transfers. Observation on 11/20/19 at 2:26 p.m. showed a certified nursing assistant (CNA) (#4) transferred Resident #9 from the bathroom to the recliner utilizing a sit-to-stand mechanical lift. The resident hung from the harness in a semi-seated position and failed to bear weight. As the harness straps pulled upward into Resident #9's axillae, his shoulders raised and right elbow extended horizontally while his hemiplegic left arm hung at	F 689	To ensure Resident #9, Resident #11 and any other resident in the facility remain as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents: Resident #9, Resident #11 and all other resident using a sit to stand mechanical lift transfer had PT or OT review their transfers to ensure sit to stand mechanical lift is appropriate and safe method of transfer. All other residents are reviewed upon admission, quarterly, annually, and with any significant change MDS to ensure each resident receives the adequate supervision and assistance devices to prevent accidents. CNAs received education on sit to stand mechanical lift transfers during the 12/17/19 meeting. A demonstration on how to complete a proper transfer using a sit to stand mechanical lift was presented by the Facility QA Nurse. CNAs completed a return demonstration to ensure they were able to utilize sit to stand mechanical lift appropriately. Any CNAs not at the meeting will be inserviced on their next scheduled work day. Education included that residents	

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F 689	Continued From page 13 his side. - Resident #11's medical record, reviewed on all days of survey, identified diagnoses including pain. The quarterly MDS, dated 09/06/19, identified assistance is required for transfers. Observations showed the following: * 11/18/19 at 3:03 p.m., a CNA (#1) raised Resident #11 in a sit-to-stand mechanical lift and provided incontinence cares. The resident hung from the harness in a semi-seated position and failed to bear weight. As the harness straps pulled upward into Resident #11's axillae, her shoulders raised to ear level and elbows extended horizontally. * 11/20/19 at 9:50 a.m., a CNA (#2) transferred Resident #11 from the bathroom to her recliner utilizing a sit-to-stand mechanical lift. Resident #11 did not bear weight and was in a semi-seated position as she hung from the harness. As the harness straps pulled upward into Resident #11's axillae, her shoulders raised to ear level and elbows extended horizontally. * 11/20/19 at 11:20 a.m., a CNA (#2) transferred Resident #11 from her recliner to the bathroom utilizing a sit-to-stand mechanical lift. Resident #11 did not bear weight and was in a semi-seated position as she hung from the harness. As the harness straps pulled upward into Resident #11's axillae, her shoulders raised to ear level and elbows extended horizontally. During an interview on the morning of 11/21/19, an administrative nurse (#6) confirmed facility staff should ensure residents bear weight when utilizing the stand lift and should ensure the harness is not pulling upward/putting pressure on	F 689	need to bear weight properly to lower extremities, apply sling properly to avoid scapular winging, if a resident has any type of paralysis to the extremity, that limb needs to be supported properly during the transfer. DON/Designee will complete QA monitoring on Resident #9, Resident #11 and any other residents using a sit to stand mechanical lift weekly X 1 month, monthly X 3 months, and quarterly thereafter X 1 year to ensure proper use of stand lift transfers are completed. Results of QA audit will be reported to monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and will be immediately corrected.	

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F 689	Continued From page 14 their axillae.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure proper respiratory care for 2 of 3 sampled residents (Resident #15 and #35) with orders for oxygen therapy. Failure to ensure oxygen is administered and provided as ordered may complicate a resident's respiratory status. Findings include: Review of the facility policy titled ". . . OXYGEN ADMINISTRATION" occurred on 11/21/19. This undated policy, stated, "Oxygen shall be administered by physician order . . . OXYGEN SET UP: . . . Nasal Cannula: a. Place O2 (oxygen) outlet tips in nostrils . . ." - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included acute chronic congestive heart failure and asthma. The current physician's order, dated 11/13/19, stated, " Oxygen at 2LPM (liters per minute) per nasal cannula continuous while in	F 695	To ensure proper respiratory care is given to Resident #15 and any other resident in the facility (Resident #35 expired); the nurses received education during their 12/12/19 Nurse's meeting that oxygen orders need to be followed and monitored throughout the day to ensure the oxygen is set at the proper rate and that residents receive their oxygen as ordered. During the 12/17/19 All Staff meeting proper oxygen administration was reviewed with CNAs. Demonstration was completed with oxygen tanks and concentrator. Rates of oxygen orders will be placed on the resident concentrators and regulators of any resident using oxygen to help identify proper oxygen rate administration order. QA monitoring will be completed by Administrative Nurse or Designee to ensure oxygen is administered and provided as ordered to Resident #15 and	12/26/19

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F 695	Continued From page 15 bed-all shifts." Observation on 11/19/19 at 2:23 p.m., 11/20/19 at 1:04 p.m., and 11/20/19 at 1:48 p.m., showed Resident #15 resting in bed with oxygen on per nasal cannula and the oxygen concentrator set at 3LPM. During an interview on the morning of 11/21/19, an administrative nurse (#7) stated, she would expect Resident #15's physicians order for continuous oxygen at 2LPM per nasal cannula to be followed. The facility failed to follow the physician's ordered oxygen flow rate of 2LPM for Resident #15. - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included acute chronic congestive heart failure, pneumonia, emphysema, and palliative (end of life) care. The current physician's order stated, "Oxygen at 2LPM per nasal cannula continuous for sob [shortness of breath] and anxiety. Observation on 11/20/19 at 3:00 p.m., 3:45 p.m., and 4:55 p.m. showed Resident #35 resting in bed without oxygen on. The nasal cannula laid on a bedside table across the room. The facility failed to provide Resident #35 continuous oxygen as ordered.	F 695	any other residents receiving oxygen weekly X 1 month, monthly X 3 months, and quarterly thereafter x 1year. Results of QA audit will be reported to the monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and immediately corrected.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		12/26/19

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F 761	Continued From page 16 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, facility policy, record review and staff interview, the facility failed to ensure accurate labeling and storage of medications of 1 of 8 residents (Resident #8) observed during medication administration. Failure to correctly label, store and dispose of medications may result in medication errors. Findings include: Review of the facility policy titled, "Storage of Medications" occurred on 11/21/19. This policy, revised April 2014, stated, ". . . Ideally,	F 761	To ensure Resident #8 and any other residents drugs and biological are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable: Nurses were educated during the 12/12/19 Nurses meeting that all medications must be labeled appropriately, if they receive medication from any pharmacy that is not labeled appropriately, they need to contact the Pharmacy to label the medication or the medication will be returned. When the VA	

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F 761	Continued From page 17 medications labeled for individual residents are stored separately. If separate storage is not possible or feasible, individual resident's medications and floor stock medications should be clearly labeled as such to easily differentiate between the two . . . outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy . . ." Observation of medication administration on 11/21/19 at 9:03 a.m. showed a handwritten, outdated insulin pen (open date of 09/03/19). The insulin pen lacked a label identifying the residents full name, medication, dose, time, date, physician, and pharmacy. The insulin pen in the medication drawer was with other residents medications. During an interview on 11/21/19 at 9:03 a.m., an administrative nurse (#7) stated the label on the insulin vial was incorrect.	F 761	Pharmacy is involved, our local Pharmacy will provide a proper label to ensure VA residents receive the proper labeled medications in a timely manner. QA monitoring will be completed by DON or assigned Designee on Resident #8 and random sample of 20% of residents population weekly x1 month, monthly x 3 months, and quarterly thereafter x 1 year. Results of QA audit will be reported to the monthly QA Committee meeting for review. Any issues identified will be reported to the Administrator and will be immediately corrected.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/26/19

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F 880	Continued From page 18 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 19 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to follow infection control practices for 5 of 23 sampled residents (Resident #8, #9, #11, #12, and #36) and 1 supplemental resident (#188). Failure to follow infection control practices related to hand hygiene during toileting/personal cares (Resident #9, #11, #12, and #36) and wound cares (Resident #8 and #188), has the potential to spread infection and communicable diseases to other residents, personnel, and visitors. Findings include: WOUND CARE Review of the facility policy titled "PREVENTION OF WOUND INFECTIONS" occurred on 11/21/19. This policy, dated 2009, stated,	F 880	To ensure the facility follows infection prevention and control practices related to hand hygiene for Resident #8, Resident #9, Resident #11, Resident #12, Resident #13 and Resident #36 and infection control practices with wound care for Resident #8 and Resident #188 and any other residents in the facility; Education was held during the Nurse's meeting on 12/12/19 regarding hand hygiene and wound care. Wound Care Prevention inservice was completed by the facility consulting Wound Care Clinician. Dressing change guidelines were reviewed with nurses. Education included hand hygiene, utilizing aseptic technique when preparing supplies during treatment and how to apply topicals with clean cotton tipped applicator and always a	

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F 880	Continued From page 20 "PURPOSE: To insure appropriate technique in doing dressing changes. Policy: . . . DECUBITUS AND STASIS ULCERS . . . clean technique [routine handwashing, hand drying, and wearing non-sterile gloves] is used . . . " Review of the facility policy titled "WOUND CARE/TREATMENT GUIDELINES" occurred on 11/21/19. This policy, dated 2009, stated, " PURPOSE: To provide excellent wound care to promote healing. GUIDELINES: . . . Supplies should be placed on a clean surface. . . . A medication tube or bottle lip should not touch any item. . . ." - Observation on 11/20/19 at 10:58 a.m., showed a staff nurse (#10) measured Resident #8's wound with a paper ruler, and with the same gloved hand, dipped a finger into a medication jar, wiped the medication onto a sterile piece of gauze, and applied the medication/gauze onto the resident's wound. - Observation on 11/20/19 at 2:22 p.m., showed a staff nurse (#10) donned gloves, cleansed Resident #188's buttock wound, ripped off a paper ruler from a dressing package, placed the paper ruler into her mouth, and secured it with her teeth. The nurse then used this same paper ruler to measure the resident's wound. The staff nurse (#10) failed to utilized appropriate infection control practices while performing wound care for Residents #8 and #188. HAND HYGIENE Review of the facility policy titled "Hand Hygiene"	F 880	clean applicator each time it is dipped into the container. Nursing staff completed return demo to wound care specialist using proper asceptic technique. Education also included how to sanitize equipment such as stand lifts. Education on hand hygiene was given at the All Staff Meeting on 12/17/19. A hand washing demonstration was completed by the QA Nurse. A handout on hand hygiene was distributed to staff. Sanitation of equipment after use was also discussed. During the return demonstration of the sit to stand transfers, CNAs demonstrated sanitation of lift. Any employee not at meeting will receive education upon return to work. QA monitoring will be completed by the Infection Control Nurse or assigned Designee to ensure infection control practices of hand hygiene are followed for Resident #8, Resident #9, Resident #11, Resident #12, Resident #13, Resident #36 and infection control practices are followed during wound care for Resident #8 and Resident #188 and random sample of residents. Results of QA audit will be reported monthly to the QA Committee. Any issues identified will be reported to the Administrator and immediately corrected.	

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F 880	Continued From page 21 occurred on 11/21/19. This undated policy stated, ". . . Handwashing . . . When hands are visibly dirty or . . . soiled . . . and in case of a resident with spore-forming organisms . . . perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water. . . . If hands are not visibly soiled, use an alcohol-based rub . . ." Observations showed the following: * On 11/18/19 at 3:03 p.m., a certified nursing assistant (CNA) (#1) donned gloves, provided incontinence cares for Resident #11, transferred the resident into the recliner via a stand lift, removed the resident's shoes/applied blue heel boots, covered her with a blanket, raised the foot rest, and hung the sling on the bathroom door before removing her gloves. The CNA (#1) failed to remove her gloves and perform hand hygiene after providing incontinence cares and prior to completing other tasks. * On 11/20/19 at 9:50 a.m., a CNA (#2) exited the bathroom with Resident #11 after providing incontinence cares. The CNA (#2) transferred Resident #11 into the recliner utilizing a mechanical sit-to-stand lift and offered her a drink of water, prior to exiting the room with the lift. The CNA (#2) failed to sanitize the lift prior to exiting the room/returning it to the storage area. * On 11/20/19 at 12:42 p.m., a CNA (#5) donned gloves, provided incontinence cares for Resident #12, and assisted her to stand/pivot into the wheelchair. The CNA (#5) removed her gloves, offered Resident #12 the opportunity to wash her hands, assisted her to stand/pivot into the bed, removed the gait belt from around the resident's waist, placed a clean clothing protector around her neck/shoulders, removed her glasses,	F 880		

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F 880	Continued From page 22 offered her a drink of water, ensured the resident's call light was within reach, and then performed hand hygiene. The CNA (#5) failed to perform hand hygiene after removing her gloves and prior to completing other tasks. * On 11/20/19 at 2:26 p.m., a CNA (#4) donned gloves, provided incontinence cares for Resident #9 after having a bowel movement. The CNA (#4) removed her gloves, transferred the resident into the recliner utilizing a sit-to-stand mechanical lift, placed a pillow behind his shoulders, ensured the resident's call light was within reach, handed him the water mug, and removed the garbage prior to exiting the room with the lift. The CNA (#4) failed to perform hand hygiene after removing her gloves and prior to completing other tasks, and failed to sanitize the lift prior to exiting the room/returning it to the storage area. * On 11/20/19 at 3:52 p.m., after assisting Resident #36 with incontinence cares, a CNA (#4) removed her gloves, transferred Resident #36 into the hallway, re-entered her room to turn off the call light, and exited the room without performing hand hygiene. The CNA (#4) failed to perform hand hygiene after removing her gloves, prior to completing other tasks, and prior to exiting the room.	F 880		