STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355103	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 12/04/17 and completed on 12/07/17, the sample included 14 residents for review and 3 closed records for review.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 sampled resident (Resident #9) observed self administering medications in the dining room. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "SELF-ADMINISTERED MEDICATIONS AND TREATMENTS IN RESIDENTS ROOM" occurred on 12/07/17. This policy, dated 07/01/17, stated, ". . . Procedure: . . . If a resident request [sic] to not be supervised taking their medications at mealtime, read over Policy and Procedure on Allowing Residents to take Oral Medications without Supervision in the dining room and fill out the Assessment form."	F 554	On 12-11-17 D.O.N. completed a self-administration of Medication form for resident #9. All current residents who can safely self administer medications in the dining room and any newly admitted residents that can self administer medications in the dining room have the potential to be affected. Corrective action as follows: 1) D.O.N. reviewed and updated Policy and Procedure on self administration of medications in dining room. D.O.N. added to the checklist for new admissions and care plan checklist to include self administration of medications in dining room. 2) D.O.N. / R.N. will reassess residents able to self-administer medications in dining room to insure that they continue to be able to safely self administer medications in the dining room. All resident able to self-medicate to be	1/10/18

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

Electronically Signed | 12/24/2017

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F 554	Continued From page 1 Observation on 12/06/17 at 8:48 a.m. showed an unidentified staff member left a medication cup containing Resident #9's morning medications at the dining room table and returned to the medication cart. The resident poured the pills onto table and self-administered one pill at a time. Review of Resident #9's medical record identified a diagnosis of schizoaffective disorder. Morning medications included vitamin C and D, Lasix (a diuretic), metformin (for diabetes), Probiotic, multivitamin, and Risperdal (an antipsychotic medication). Resident #9's record failed to include a SAM assessment. During an interview on the afternoon of 12/06/17, an administrative nurse (#2) confirmed the facility failed to complete a SAM assessment for Resident #9.	F 554	reassessed by 1-10-2018. 3)On 12-19-2017 a nurses meeting was held to re-educate nurses on the self-administration of medications in dining room form and reviewed list of all current residents that are self-medicating in the dining room. 4)On 12-28-2017 A Med. Aide II meeting will be held to re-educate all Med. Aide II's on the self administration of medication in dining room form, and review list of all current residents that are self-medicating in the dining room. 5) By 1-10-2018 D.O.N./R.N. will have observed medication aides giving meds to those residents that can self-administer meds in dining room. 6)Q.A. form to be developed and completed by D.O.N. / R.N. twice a week for one week, and then monthly for one year. D.O.N / R.N. to report to QAPI team at quarterly meetings.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		1/10/18

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F 578	Continued From page 2 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, review of facility policy, and staff interview, the facility failed to ensure the medical record for 1 of 14 sampled residents' (Resident #30) medical record accurately reflected the resident's Advanced Directive requesting CPR (cardio pulmonary resuscitation). Failure to ensure Resident #30's medical record accurately reflected her wishes has the potential to limit her access to life-sustaining services.	F 578	Corrective actions was taken on 12-7-2017; SSD spoke with resident #30 and confirmed that the code status form dated 10/6/2017 was consistent with her wishes concerning Code Status. SSD faxed a copy of the Code Level form dated 10/6/2017 to resident #30's primary physician. All residents currently residing in facility and any newly admitted residents are at	

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F 578	Continued From page 3 Findings include: Review of the facility policy titled "Advanced Directives" occurred on 12/07/17. This policy, dated 07/01/17, stated, ". . . It is the policy of this facility to ensure that a resident's choice about advanced directives be respected. . . . The Social Services Designee will review annually with the resident his or her advanced directives to ensure that they are still the wishes of the resident. . . . The facility will notify the attending physician of advanced directives so that appropriate orders can be documented in the resident's medical records and plan of care. . . ." Review of Resident #30's medical record occurred on all days of survey. Both the face sheet and current physician's orders identified, "DNR [do not resuscitate]." The care conference note, dated 10/26/17, identified, "No CPR. Advanced Directives have on file." The current care plan failed to address her wishes/advanced directives. In contrast, a binder at the nurses' station containing each resident's "Code Level Directive," identified, on 10/06/17, Resident #30 indicated she wished "CPR [to] be performed." The admission Minimum Data Set (MDS), dated 10/10/17, identified Resident #30 as cognitively intact. During an interview on 12/06/17 at 8:04 a.m., she confirmed she wanted CPR to be performed in case of an emergency. During an interview on 12/06/17 at 10:01 a.m., when asked who is responsible for ensuring the	F 578	risk to be affected therefor the following corrective action will be taken: 1) On 12-21-2017 the SSD and Administrator reviewed / revised the Code Status Form and the Care Conference Note template. 2) SSD and/or Administrator will review with resident/or resident's representative the current code status on file; Updated forms will be obtained if necessary and any changed Code Status form will be faxed to primary physician by 1-10-2018. 3) Each resident/or resident's representative will be questioned about their Code Level at each care conference. If changes are made to Code Level the SSD will obtain necessary signatures and fax new Code Level form to resident's primary physician. 4)Q.A. Form developed on 12/21/2017 to be completed by SSD for all residents. This Q.A. will be completed on six (6) random charts weekly for one month, monthly for six (6) months and then quarterly thereafter for one (1) year. It is the S.S.D. responsibility to report findings of Q.A to QAPI team at quarterly meetings.	

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F 578	Continued From page 4 resident's wishes/advanced directives are accurately reflected in the medical record, a Social Services staff member (#1) stated, "I ask at the care conference if they have made any changes to their advanced directive. Then I . . . scan it (Advanced Directive or Code Level Directive Sheet) in and put it in . . . the binder at the front desk . . . Right next to the nurses desk there is a list of all residents and their codes. Those that want CPR are highlighted. . . . I would update it . . . on the Face Sheet . . . I would call the hospital and talk with them if the Physician's Orders don't match the Code Level Directive Sheet. . . ." Following the interview, the list of all residents and their current code status was reviewed. The list identified "DNR" next to Resident #30's name. During an interview on 12/06/17 at 11:21 a.m., when asked why the current code status identified in Resident #30's medical record did not match her wishes, the Social Services staff member (#1) stated, "I don't know (why they don't match). . . . I will have to call the doctor and follow-up with them."	F 578		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an	F 645		1/10/18

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F 645	Continued From page 5 independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the	F 645		

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F 645	Continued From page 6 condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure an accurate Pre-Admission Screening and Resident Review (PASARR) for 1 of 1 sampled resident (Resident #32) reviewed with PASARR services. Failure to accurately complete the PASARR screening created the potential for not identifying/providing needed mental health services. Findings include: Review of the medical record for Resident #32 occurred on all days of survey. Diagnoses included schizoaffective disorder, anxiety, and depression. A Level 1 PASARR screening completed on 11/03/16 failed to identify Resident #32's diagnosis of schizoaffective disorder.	F 645	Corrective Action was taken on 12/7/2017 when S.S.D. requested that a Level II PASSR screen be completed for resident number thirty-two (32). On 12-13-2017 a Level II PASSR screen was completed by DDM/ASCEND nurse for resident number thirty-two (#32) and recommendations implemented. On 12-22-2017 SSD and Administrator reviewed PASSR information sheets; and SSD completed on-line LOC training offered by ASCEND. All new admissions are at risk for the deficient practice, therefore the following corrective action will be implemented by 1-10-2018: 1)A Pre-admission checklist will be created to insure that PASSR Level I is completed PRIOR to admission to nursing	

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F 645	Continued From page 7 During an interview on 12/05/17 at 3:09 p.m. a social service staff member (#1) confirmed Resident #32 has a diagnosis of schizoaffective disorder and needs a Level 2 PASARR level 2 screening.	F 645	home. (If a PASSR Level I screen has not been completed the admission will be put on hold until a PASSR Level I screen has been completed and results received.) Prior to admission SSD, R.N., D.O.N. and/or Administrator will request a copy of current medication list (including any medications discontinued within the last year) from discharging entity; individual themselves and/or residents representative. 2) A Q.A. form has been developed and completed by SSD and/or Administrator for all existing residents by 1-10-2018 to insure PASSR information is on file. 3) Q.A. will be completed prior to any new admissions to insure that PASSR Level I has been completed and recommendations followed prior to resident being admitted to nursing home. 4) Q.A. form will be completed after the psychiatrist and/or primary physician completes rounds to determine if any new anti-psychotic medications have been prescribed and PASSR Level II needed. This Q.A. will be completed on 6 random charts weekly for one month, and then monthly thereafter. 5) Q.A. form will be completed upon a residents return from hospitalization to determine if a PASSR Level I or II needs to be requested. 6) The SSD will report all findings to Q.A.P.I team at quarterly meetings. 7)A R.N. and / or D.O.N. will review all admission information PRIOR to acceptance.	
F 657	Care Plan Timing and Revision	F 657		1/10/18

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F 657 SS=E	Continued From page 8 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. (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, review of facility policy, resident interview, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 5 of 14 sampled residents (Resident #10, #16, #25, #28, and #30). Failure to revise the care plans limited staff's ability to communicate care	F 657	By 1-10-2018 the Inter-disciplinary Care Plan team will have reviewed / revised the care plans for resident #10, #16, #25, #28 and #30 to reflect the updated information on antipsychotic, antianxiety, Hearing status and code status. All residents are at risk to have	

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F 657	Continued From page 9 needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "POLICY AND PROCEDURE ON CAREPLANS/CARE CONFERENCES" occurred on 12/07/17. This policy, revised on 09/08/15, stated, "POLICY: To ensure that all is done to meet the needs of the particular resident to meet their highest practical standard care [sic]. . . . Care plans will be review/updated at least quarterly and prn [as needed]. . . ." - Review of Resident #25 medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and a psychotic disorder. Medications included Risperdal (an antipsychotic) 0.125 milligrams (mg) three times a day. The significant change Minimum Data Set (MDS), dated 10/25/17, identified no verbal or physical behaviors and wandered daily. Resident #25's care plan failed to address the use of an antipsychotic medication and the behaviors associated with its use. - Review of Resident #10's medical record occurred on all days of survey. The quarterly MDS, dated 09/20/17, identified Resident #10 had moderate difficulty hearing (with a hearing appliance in place) even in situations where the speaker increased his/her volume and spoke distinctly. The current care plan identified, "I have difficulty hearing when I am in large groups. I do not wear hearing aides."	F 657	antipsychotic, antianxiety, Hearing status and code status omitted from their care-plans; therefore the by January 10, 2018 the Inter-disciplinary Care Plan team will have completed a Q.A. on all current residents to insure all antipsychotic medications, antianxiety medications, hearing status and use of hearing devices and code status are included on the current care plans. Once a month for two years three (3) random charts and any new or re-admitted resident's charts will have Q.A. completed by D.O.N, R.N., SSD and/or Administrator to insure that their care plans include any antipsychotic, antianxiety, Hearing status and code statuses if applicable. A comprehensive Care Plan Checklist was developed by 1-10-18 to insure that hearing devices/needs, antipsychotic, antianxiety medications and Code Status are discussed at Quarterly Care Conference Meetings and are included on care plans. By 1-10-18 all nurses that are part of the care planning team will be re-educated on what specific information needs to be included on care-plans. SSD, D.O.N. and / or Administrator will review the comprehensive Care Plan Checklist with all members of the care planning team.	

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F 657	Continued From page 10 During an interview on 12/06/17 at 10:01 a.m., when asked if Resident #10 had any hearing issues, the Social Services staff member (#1) stated, "Since I have been here, [Resident #10] hasn't had any hearing aides. She just had an amplifier." Resident #10's care plan failed to address her use of an amplification system. - Review of Resident #16's medical record occurred on all days of survey. The quarterly MDS, dated 10/03/17, identified Resident #16 received an antipsychotic medication. The current physician's orders showed she received the psychotropic medication Seroquel twice daily. During an interview, on 12/06/17 at 3:22 p.m., a nurse (#4) stated, "[Resident #16] was initially put on the medications for hallucinations . . . She would become distraught and cry." Resident #16's current care plan failed to address her use of an antipsychotic medication. - Review of Resident #28's medical record occurred on all days of survey. The quarterly MDS, dated 10/28/17, identified Resident #28 demonstrated verbal behavior symptoms directed toward others and received antianxiety and antipsychotic medications. The current physician's orders showed she received the psychotropic medications Olanzapine daily and Haloperidol on an as-needed basis. Resident #28's current care plan failed to address her use of antipsychotic medications.	F 657		

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F 657	Continued From page 11 During an interview, on 12/07/17 at 10:02 a.m., an administrative nurse (#2) stated, "If [the antipsychotic medications were] for behaviors, then yes, I would include [them] . . . on the care plan." - Review of the facility policy titled "Advanced Directives" occurred on 12/07/17. This policy, dated 07/01/17, stated, ". . . The facility will notify the attending physician of advanced directives so that appropriate orders can be documented in the resident's medical records and plan of care. . . ." Review of Resident #30's medical record occurred on all days of survey. The "Code Level Directive," dated 10/06/17, identified Resident #30 wished "CPR [cardio pulminary resuscitation] [to] be performed." During an interview on 12/06/17 at 8:04 a.m., Resident #30 confirmed she wanted CPR to be performed in case of an emergency. Resident #30's current care plan failed to address her wishes/advanced directive of wanting to receive CPR.	F 657		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in	F 685		1/10/18

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F 685	Continued From page 12 the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policy, and group/staff interview, the facility failed to ensure residents received proper treatment and/or assistive devices to maintain their hearing abilities for 1 of 1 resident (Resident #10) who utilized an amplification system. Failure to assist Resident #10 and/or her family member in locating resources, making appointments, and arranging for transportation to replace her lost amplifier, resulted in her feelings of frustration related to her inability to hear those attempting to communicate with her. Findings include: Review of the facility policy titled "Lost, Misplaced, Damaged Items" occurred on 12/07/17. This undated policy stated, ". . . Complaints of lost, misplaced or damaged items will be promptly and thoroughly investigated. . . . All other lost or missing items will be investigated by the Social Service Designee, Housekeeping and Nursing Departments. . . . Upon learning of the lost or missing item, staff will search for the item, and . . . If not found within thirty days, advise the resident and family. At this time all parties will then come to an agreement regarding replacement of item. The outcome is noted on the "Lost, Misplaced, Damaged Items" form. . . ." Review of Resident #10's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 09/20/17,	F 685	Corrective action was taken for Resident #10 on 12-07-2017 when SSD placed a call to resident #10's son to ask him about the replacement of amplifier. Resident #10's son stated, "I replaced the missing amplifier with another amplifier that goes in the ear but mom did not like it so I am looking for one that goes over the ear that she will like." On December 19, 2017 SSD advised Administrator that resident #10's son had not yet replaced hearing amplifier. It was decided that the facility would replace amplifier since there was NOT clear documentation as to who was at fault for losing the amplifier. All residents are at risk for deficient practice therefore the following corrective action has been implemented: 1) SSD, D.O.N. and Administrator have reviewed/revised the Policy and Procedure for Missing/Lost/Misplaced Items. A mandatory all staff in-service will be held on 1-8-2018 to re-educate all staff on the updated Policy and Procedure for Missing/Lost/Misplaced Items. 2) Q.A. form has been developed and will be completed twice a week for one (1) month, once (1) a week for three (3) months and once a month for six (6) months and quarterly thereafter for two (2) years. 3)SSD will report to findings to QAPI team	

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F 685	Continued From page 13 identified Resident #30 as cognitively intact and having moderate difficulty hearing (with a hearing appliance in place) even in situations where the speaker increases his/her volume and speaks distinctly. The current care plan identified, "I have difficulty hearing when I am in large groups. I do not wear hearing aides." The care plan failed to address Resident #10's use of an amplification system. During the group interview on 12/05/17 at 09:15 a.m., when given the opportunity to discuss concerns, Resident #10 reported she "lost her hearing aid [amplifier] a while back" and had reported it to the Social Worker. During interview on 12/06/17 at 10:01 a.m., when asked if Resident #10 had any hearing issues, the Social Services staff member (#1) stated, "Since I have been here, [Resident #10] hasn't had any hearing aides. She just had an amplifier. . . . [Resident #10] said [her amplifier] went missing here and wasn't able to be found." When asked what staff are expected to do when an item goes missing, the Social Services staff member (#1) stated, "We investigate, search [the] room, I let housekeeping know, department heads, and if we can't find it, we replace [the missing item]." When asked if/when she was informed the amplifier went missing, she (#1) stated, "The only [Lost/Misplaced/Damaged Items form] I have about [Resident #10's amplifier] was in May. Her son said, 'It's been missing awhile and he was going . . . to go to Scheels . . . to get her a new one.'" [The Lost/Misplaced/Damaged Items form was dated 05/02/17.] When asked if Resident #10's amplification system had been replaced, the	F 685	at quarterly meetings.	

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F 685	Continued From page 14 Social Services staff member (#1) stated, "I haven't heard. . . . I guess the son said he was going to replace it. I'll see if he wants us to replace it. Yeah, I should have followed up with it." During interviews on 12/06/17 at 10:50 a.m. and 11:03 a.m., the Social Services staff member (#1) reported, "[Resident #10's] son said he brought in [an amplifier] 3-4 months ago [three months after the amplification system first went missing] and [Resident #10 said although] she uses the little ones that [her son] brought in . . . she likes the over-the-ear amplifier she had before. . . . I am going to look to see what I can find, to have it replaced."	F 685		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		1/10/18

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F 755	Continued From page 15 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to establish a system to account for all controlled medications stored in 1 of 1 medication rooms. Failure to assure all controlled medications are accounted for and periodically reconciled has the potential for medication loss or diversion of medications. Findings include: Observation of the locked medication storage area in the nurses's station occurred on 12/05/17, at 2:47 p.m., with a nurse (#2). Observation showed a locked cabinet in the medication room contained full cassettes of controlled medications. The nurse stated the medications that do not fit in the medication cart are placed in the cabinet. The medications in the cabinet are signed in when delivered by pharmacy, and when the medication is needed, the cassette is signed out and placed in the medication cart.	F 755	All residents who receive narcotics are at risk to be affected by this deficient practice, therefore the following corrective action has been taken: 1) D.O.N. and Administrator counted and documented all narcotics in the cupboard on 12/7/2017. 2) The Policy and Procedure for Storage of Narcotics was updated to include that the narcotics in the cupboard be counted at each shift change. 3)On 12-19-2017 a nurses meeting was held to discuss the updated Storage of Narcotics Policy. 4)On 12-28-2017 a meeting will be held with all Medication Aide's to discuss the updated Storage of Narcotics Policy. 5) A QA form was developed to insure all Narcotics are counted and reconciled. This Q.A. will be completed by D.O.N and/or Administrator daily for one (1) week, weekly for one (1) month and once (1) a month for one year.	

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F 755	Continued From page 16 During an interview on 12/07/17, at 10:33 a.m., an administrative nurse (#1) stated, the controlled medications in the medication room cabinet are not counted on a regular basis, and agreed they do not have a good system of accountability for controlled medications.	F 755	6) The D.O.N. and/or Administrator will report findings to QAPI team at quarterly meetings.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and medication checklist, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 3 of 5 residents (Resident #4, #19, and #24) observed during medication pass. Three medication errors occurred during staff administration of 26 medications, resulting in a 11% error rate. Failure to ensure medications are administered correctly may result in an adverse side effects. Findings include: Review of the facility policy titled "How To Use An Insulin Pen" occurred on 12/07/17. This policy, dated September 2017, stated, " . . . 8. While holding the insulin pen in an upright position, push the injector button till the pen gets to zero. Be sure to check that insulin comes out of the needle. This ensures that no air is in the pen. . . ."	F 759	No corrective actions for residents #4, #19 and #24 can be taken as the mediations have already been given. All residents receiving insulin and sublingual medications are at risk to be affected, therefore the following corrective action has been implemented: 1) On 12-08-2017 D.O.N. reviewed and revised Policy and Procedure on how to give insulin and sub-lingual medications. 2) On 12-08-2017 D.O.N. created a list of residents that are currently receiving insulin and/or sublingual medications. 3)On 12-19-2017 a nurses meeting was held and D.O.N. reviewed Policy and Procedure of Administration of sublingual medications and insulin with nursing staff. D.O.N. also reviewed the list of residents currently receiving insulin and/or sublingual meds. 4) The nursing staff demonstrated how to correctly prime insulin pen and the correct	1/10/18

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F 759	Continued From page 17 Review of the facility form titled "Checklist For The Administration Of Oral Medications" occurred on 12/07/17. This checklist stated, " . . . 6. Gave sublingual meds (medications) under the tongue with instructions to the individual to keep med under tongue until dissolved. . . ." - Physician orders for Resident #19 included Hyoscyamine 0.125 milligram tablet sublingual every four hours for secretion of saliva. Observation on 12/05/17 at 8:19 a.m. showed a Medication Aide II (#6) administered Resident #19's morning medications which contained Hyoscyamine and the resident swallowed the medications. The Medication Aide II (#6) failed to instruct the resident to take the Hyoscyamine sublingually. - Observation on 12/05/17 at 11:31 a.m. showed a licensed nurse (#10) prepared Resident #24's Novolog insulin pen for injection. After placing the needle on the insulin pen, the nurse (#10) failed to remove the needle cap before priming the insulin pen to observe for no air in the pen. Observation on 12/05/17 at 11:37 a.m. showed a licensed nurse (#10) prepared Resident #4's Novolog insulin pen for injection. After placing the needle on the insulin pen, the nurse (#10) failed to remove the needle cap before priming the insulin pen to observe for no air in the pen. During an interview on 12/06/17 at 5:04 p.m., an administrative nurse (#2) stated she would expect the nurse to prime the insulin pen with the cap off.	F 759	procedure for giving a sublingual medication. 5) On 12-28-2017 a medication aid meeting will be held to re-educate medication aides on the correct procedure for giving sublingual medications. At this time D.O.N. will review with Medication Aids a list of residents that are currently receiving sublingual medications. 6)Q.A. form has been developed to insure that insulin pens are primed correctly and sublingual medication is given correctly. Q.A. to be completed by D.O.N. and/or R.N. weekly for one month, monthly for three months and quarterly thereafter for one year. D.O.N. and/or R.N. to report to Q.A.P.I. team at quarterly meetings.	

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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 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, facility policy review, and staff interview, the facility failed to assure safe and secure storage of medications for 1 of 1 medication carts during medication pass. Failure to store all medications securely may result in unauthorized access to medications. Findings include:	F 761	No corrective action can be taken as this did not affect a particular resident. All residents are at risk for facility to NOT have safe and secure storage of medications, therefore the following corrective action has been implemented: 1) 12-19-2017 a nurses meeting was held to re-educated nursing staff on the policy and procedure for labeling and storage of	1/10/18

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F 761	Continued From page 19 Review of the facility policy titled "Policy and Procedure on storage of medications" occurred on 12/07/17. This policy, dated 07/01/17, stated "Policy: For the safety of the residents . . . all medications shall be kept in the medication cart and/or the treatment cart when not in the med [medication] room. Medication cart will be locked when not within eye view." Observation on 12/05/17 at 8:11 a.m. and 8:19 a.m. during medication pass showed a Medication Aide II (#6) at the medication cart located in the PT/OT (physical therapy/occupational therapy) room, preparing medications. A table located along the right side of the medication cart contained several bottles of OTC (over-the-counter) medications and bottles of prescription medications. Observation showed a Restorative Therapy aide (#12) and a resident were present in the PT/OT room at the time. During the observation, the Mediation Aide II left the medication cart and the PT/OT room to deliver medications to residents located in the dining room. Observation showed the Medication Aide II not within eye view of the medication cart when in the dining room. The Medication Aide II left the medications on the table during the entire medication pass. During an interview on 12/05/17 at 8:53 a.m. the Medication Aide II (#6) confirmed she left the medications on the table during medication pass.	F 761	medications. 2) 12-28-2017 a med aide meeting was held to re-educate the medication aides on the policy and procedure for labeling and storage of medications. 3) D.O.N. observed each medication aide to insure that medications were properly stored 4) A Q.A. form has been developed and will be completed by D.O.N. and/or R.N. once a week for one (1) month and monthly thereafter for one (1) year. 5) D.O.N. and/or RN will report finding to Q.A.P.I team at quarterly meetings.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides-	F 805		1/10/18

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F 805	Continued From page 20 §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure each resident received food in a form designed to meet the individual resident needs for 2 of 2 sampled residents (Resident #6 and #25) with physician's orders for ground meat. Failure to prepare food at the right consistency may result in reduced meal intake and choking. Findings include: Review of the facility policy titled "Diet Orders" occurred on 12/07/17. This policy, dated 2008, stated, ". . . Procedure: . . . 3. Diets will be offered as ordered by the physician. . . ." Review of the facility policy titled "Dysphagia Diets" occurred on 12/07/17. This policy, dated 2008, stated, ". . . The food service department will be responsible for preparing and serving the diet as ordered. . . ." - Observation on 12/05/17 at 11:43 a.m. showed Resident #25 seated at an assistive table with an unidentified certified nursing assistant (CNA) next to her. The resident's meal included chicken. The CNA removed the chicken from the bone, cut it into bite size pieces, and Resident #25 ate the chicken independently. Review of Resident #25's medical record occurred on all days of survey. A physician's order stated, "Diet: Mechanical Soft texture with	F 805	Corrective action was taken on 12/7/2017 when Dietary Manager spoke to Dietary Aide #11 at end of her shift and re-educated her on the specific diets for resident #6 and #25. Dietary Manager reviewed "Diet List" form attached to wall with dietary aide #11. (See verbal warning sheet). Also, Dietary Manager re-printed "Diet List" using a larger font and affixed two copies to both sides of serving window. All residents with a therapeutic diet order are at risk to be affected by staff not following diet orders, therefore the corrective action has been implemented: 1) On 12-28-2017 a Mandatory Dietary In-service will be held to re-educate the dietary staff on the importance of following diet orders. 2) A Q.A. form will be completed by dietary staff daily for one (1)week, once a week for three (3) months and once a month for one (1) year. 3) The dietary manager will report findings to Q.A.P.I team quarterly.	

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F 805	Continued From page 21	F 805		

ground meat." The resident's care plan stated, ". . . I do not eat or drink very well anymore. I am starting to pocket food. . . . I am on a mechanical soft diet with ground meat. . . ."

- Observation on 12/05/17 during the noon meal showed Resident #6 seated at an assistive table and an unidentified CNA assisted her with chicken cut into bite size pieces.

- Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dysphagia following cerebral infarction and dementia. A swallowing evaluation by the speech therapist on 03/30/17, stated, "recommend regular textures with ground meat. . . " Physician's orders, dated 5/23/17, identify a diet of regular textures and ground meats.

An interview occurred on 12/05/17 at 11:51 a.m. with a dietary aide (#11). When asked how she knows which residents receive ground meat, she referred to a "Diet List" affixed to the wall in the kitchen. This dietary aide stated she had forgotten to grind the chicken for the noon meal.

During an interview on 12/06/17 at 3:38 p.m., an administrative dietary staff member (#9) stated there are five residents who receive ground meats, which include Resident #6 and #25. The staff member (#9) confirmed staff should have served these residents ground chicken. She stated there is a paper posted by the serving line stating which residents receive ground meats. Observation showed two documents posted (one on each side of the serving line) which listed the residents diets, including those who receive ground meat.

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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. 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	F 880		1/10/18

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	355103	A. BUILDING _____ B. WING _____	12/07/2017

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F 880	Continued From page 23 infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 4 of 4 sampled residents (Resident #6, #9, #12, and #24). Failure to practice infection control related to perineal cleansing (Resident #24), hand hygiene (Resident #9), storage of a urinary	F 880	Corrective Action for resident #6, #9, #12 and #24 cannot be taken as the date of the deficiency has already occurred. although Resident #12 had a catheter storage bag place in room. All residents are at risk for infection r/t improper hand hygiene, improper perineal	

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F 880	Continued From page 24 drainage bag (Resident #12), and enviroment cleaning (Resident #6), during cares has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of the facility policy titled " Hand Hygiene" occurred on 12/07/17. This policy, dated 09/08/17, stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: . . . Before and after resident contact . . . Before and after assisting a resident with personal care (e.g.[such as],oral care, bathing); . . . Upon and after coming in contact with a resident's intact skin, (e.g. when taking a pulse, or blood pressure, and lifting a resident) . . . Before and after assisting a resident with toileting; . . . After performing personal hygiene actions; After removing gloves or aprons; . . ." CLEANSING Observation on 12/06/17 at 8:08 a.m. showed a certified nurse assistant (CNA) (#5) entered Resident #24's bathroom, as the resident requested assistance after having a bowel movement (BM). The CNA gathered a clean brief and one disposable wipe. With gloved hands, the CNA used toilet paper to perform perineal cares, after which BM was observed on the staff's gloved hand. The CNA then cleansed the resident's rectal area with the disposable wipe, using it multiple times during cleansing. A smear of BM remained on the resident's buttock. The CNA removed her gloves and pulled up the	F 880	care and environmental cleaning. Those resident with catheters are at risk for infection and infecting others residents r/t the improper storage of catheter bags therefore the following corrective action will be implemented: 1) D.O.N., and Infection Prevention Nurse (IPN) will review and update the policy and procedure on hand hygiene, catheter bag storage and cleaning up BM. 2) By January 10, 2018 all C.N.A.'s will be re-educated on proper hand hygiene, storage of catheter bags and cleaning up of BM. 3) By January 10, 2018 all C.N.A.'s will demonstrate to IPN the proper technique for hand hygiene, storage of catheter bags and cleaning up of BM. 4) By 1-10-2018 IPN will educated all licensed staff on proper hand hygiene, proper catheter bag placement, how to properly clean perineal area and how to properly clean and disinfect any environmental area that comes into contact with BM. 5) Each licensed staff member will demonstrate the proper way to wash hands, proper placement of catheter bags and the proper procedure for disinfecting floor soiled with BM. 6) IPN will develop a Q.A. Form to monitor licensed staff can correctly perform hand hygiene, perineal cares, store catheter bags and remove BM from the floor. 7) IPN will complete Q.A. weekly for one (1) month, bi-monthly for three (3) months and monthly thereafter for one (1) year.	

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F 880	Continued From page 25 resident's brief and pants. After the CNA assisted the resident into the wheelchair, she completed hand washing in the sink. Using one wipe multiple times with visible soiling, may result in transferring contamination from one area to another and may result in a urinary tract infection. HAND HYGIENE Review of Resident #9's medical record occurred on all days of survey. A physician's order dated, 12/19/16, stated, "CONTACT PRECAUTIONS." Resident #9's care plan stated, ". . . I am on contact precautions . . ." Observation on 12/05/17 at 10:05 a.m. showed the CNA (#8) utilized a standing lift and transferred Resident #9 from her wheelchair to bed. The CNA failed to perform hand hygiene before exiting the resident's room. Observation on 12/05/17 at 10:50 a.m. showed a CNA (#8) provided care to Resident #12. The CNA (#8) removed the resident's brief which contained BM and performed perineal care. The CNA then placed a new brief and transferred Resident #12 from the bed to the wheelchair using a sit to stand lift. After removing her gloves, without performing hand hygiene, the CNA removed the sling from behind the resident, adjusted the resident's clothing, applied leg rests to the wheelchair, removed the lift from the room, cleaned the lift, returned to room and then performed hand hygiene. URINARY STORAGE BAG	F 880	8) IPN will be responsible to report findings to Q.A.P.I team at quarterly scheduled meetings.	

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F 880	Continued From page 26 Observation on 12/05/17 at 09:07 a.m. and 2:42 p.m. showed Resident #12 sitting in a recliner chair with his urinary storage bag in a round basket next to the recliner. The basket contained used tissues and a discarded red paper plate. Observation on 12/06/17 at 8:39 a.m. showed the urinary storage bag in the same basket which contained used tissues and a straw. Observation on 12/06/17 at 1:15 p.m. showed an unidentified CNA emptied the urine from the urinary storage bag and placed the bag in the basket on top of an used tissue. During an interview on 12/07/17 at 9:35 a.m., an infection control nurse (#4) stated the basket in the room is for his urinary storage bag and she expected staff to not place the bag in the basket if it contained garbage. ENVIRONMENT Observation on 12/05/17 at 8:13 a.m. showed two CNA's (#7 and #8) toileted Resident #6. As the CNA's lowered Resident #6 to the toilet and removed her incontinent brief, a small amount of formed BM fell to the floor. The CNA (#8) removed the BM from the floor using toilet paper and a gloved hand. The CNA (#8) failed to sanitize the area with a disinfectant wipe. Observation showed a container of disinfectant wipes on the floor next to the toilet.	F 880		