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	355067	A. BUILDING _____ B. WING _____	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CENTER	2900 14TH AVE S GRAND FORKS, ND 58201

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on November 13, 2016 and completed on November 16, 2016, the sample included 5 residents for complete review, 22 residents for focused review, and 3 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care for 4 of 26 sampled residents (Resident #2, #3, #10, and #18) and 3 supplemental residents (Resident #31, #32, and #33) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors and wait for a reply before entering a resident's room to ensure privacy during cares does not preserve the residents personal dignity or enhance their quality of life and places them at risk of embarrassment or emotional harm. Findings include: Review of the facility policy "Dignity and Respect" occurred on 11/16/16. The policy, revised on	F 241	1. Licensed Social Workers visited with Residents #2, #3, #10, #18, #31, and #33, regarding their rights in relation to dignity. Residents were informed of the expectation that staff knock and wait approximately five seconds prior to entering a resident's room. Resident #32 has since died. 2. All residents have the potential to be affected. The DONS attended resident council on 11/22/16 and discussed dignity and the requirement of staff to knock on doors prior to entering. A copy of the resident council minutes is posted for all residents to view. 3. A communication was sent out November 23 with education provided on the standards for knocking on resident's	12/21/16

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

Electronically Signed | 12/13/2016

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F 241	Continued From page 1 11/09/09, stated " . . . A closed door . . . shields the resident from passers-by. . . . Staff memebers shall knock before entering the resident's room. . . ." Observations during the initial tour, on 11/13/16 at 1:45 p.m., showed the following: * An unidentified staff member entered Resident #18's room without knocking/announcing himself or waiting for permission to enter. * An unidentified staff member knocked on Resident #31's door and entered her room without announcing herself and/or waiting for permission to enter. Once inside, she stated, "What do you need?" * An unidentified staff member entered Resident #32's room without knocking/announcing himself or waiting for permission to enter. * An unidentified staff member entered Resident #33's room without knocking/announcing herself or waiting for permission to enter. Observations showed the following: * 11/14/16 at 9:30 a.m., two certified nursing assistants (CNAs) (#16 and #17) knocked on Resident #3's door and entered her room without announcing themselves and/or waiting for permission to enter. * 11/14/16 at 11:21 a.m., a nurse (#16) knocked on Resident #2's door and entered her room without announcing herself and/or waiting for permission to enter. Once inside, she greeted the resident, took the resident's vitals, sanitized her hands, and exited the room. A few minutes later she reentered Resident #2's room without knocking/announcing herself or waiting for permission to enter. * 11/14/16 at 3:40 p.m., a CNA (#15) assisted	F 241	doors prior to entering. An in-service was held for licensed nurses (LNs) and CNAs to discuss resident rights and dignity on December 14. 4. The CNA mentors will complete a minimum of twenty-five random observations of staff entering resident rooms daily for five days. The Staff Development RN will be responsible to complete a minimum of twenty-five observations weekly for three weeks, then twenty-five observations monthly for the next eleven months. The results of the audits will be reported to the DONS who will report monthly at the QAPI team. The need for further audits will be determined at the discretion of the QAPI team.	

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F 241	Continued From page 2 Resident #10 with toileting cares. Observation showed while Resident #10 and the CNA (#15) were in the bathroom, a staff nurse (#11) entered the room without knocking or announcing herself and/or requesting permission prior to entering the room. * 11/15/16 at 7:50 a.m., a CNA (#18) entered Resident #2's room without knocking/announcing herself or waiting for permission to enter. During an interview on 11/16/16 at 9:00 a.m., an administrative nurse (#9) confirmed staff should first knock on the door then wait 5 to 10 seconds for a response before entering the room.	F 241		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow physician's orders regarding insulin administration for 1 of 10 sampled residents (Resident #21) who received insulin. Failure to follow physician's orders may result in hypoglycemia (low blood sugar). Findings include: Berman, Frandsen, and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc.,	F 281	INSULIN ADMINISTRATION: 1. The staff member administering the insulin for Resident #21 on November 14 was conferenced about following physician orders. The insulin order for Resident #21 was reviewed and updated per her primary physician. 2. All residents receiving insulin have the potential to be affected. All residents receiving insulin had their orders reviewed by a Licensed Nurse to ensure order is being followed correctly. 3. Educational material and communication about the survey concern with insulin administration will be given to	12/21/16

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F 281	Continued From page 3 New Jersey, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #21's medical record occurred on November 14-16, 2016. Diagnoses included diabetes mellitus with diabetic neuropathy. Current physician's orders included NovoLog (a rapid-acting insulin) 25 units subcutaneously three times a day, with the instructions "Give after meals, if she has eaten at least 50% of meals." Observation on 11/14/16 at 8:01 a.m. showed a licensed nurse (#7) entered Resident #21's room and administered 25 units of NovoLog insulin. The nurse commented prior to administration, "We'll see if I can get her out for breakfast. Wish me luck." The resident then agreed to go to the main dining room for breakfast with the assistance of the nurse. The nurse failed to ensure Resident #21 ate 50% of breakfast prior to receiving insulin. During an interview on the morning of 11/16/16, an administrative nurse (#6) stated she observed Resident #21 eating toast earlier on the morning of 11/14/16; however, the medical record lacked evidence of this intake. Review of Resident #21's medication administration records and meal intake records for September - November 15, 2016 identified the following: *09/11/16: 25 units NovoLog administered at 6:00 p.m., meal intake records identified the resident consumed 25% of her evening meal. *10/13/16: 25 units NovoLog administered at 12:00 p.m., meal intake records identified the	F 281	all licensed nurses on December 14 by the Staff Development RN. 4. The ADON is responsible to complete a minimum of three audits of insulin administration weekly for one month, then three audits monthly for three months. The ADON will report the results of the audit monthly at the QAPI team meetings. The need for further audits will be determined at the discretion of the QAPI team. PRN MEDICATION FOLLOW-UP: 1. The pain management regimens of Residents #7, #8, #9, #11, and #12 were reviewed by the RN Care Coordinator along with a review of their current pain care plan to ensure that is effective and individualized. 2. All residents receiving PRN pain medications have the potential to be affected by this. 3. Communication sent out November 23 with education provided on the standards for pain medication follow-up. An in-service was held for licensed staff to educate on the timeliness of pain medication follow-up on December 14. Policy M.3.1, Medication Administration, was updated to include that follow-up must be completed by a nurse within two hours of administration. 4. The Quality Coordinator, or designee, will complete a minimum of ten random audits of PRN pain medication administration each week for one month, then ten audits monthly for eleven months	

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F 281	Continued From page 4 resident consumed 25% of her noon meal. *10/26/16: 25 units NovoLog administered at 6:00 p.m., meal intake records identified the resident consumed 25% of her evening meal. *11/01/16: 25 units NovoLog administered at 12:00 p.m., meal intake records identified the resident consumed 0% of her noon meal. *11/07/16: 25 units NovoLog administered at 12:00 p.m., meal intake records identified the resident refused her noon meal. *11/11/16: 25 units NovoLog administered at 12:00 p.m., meal intake records identified the resident refused her noon meal. *11/14/16: 25 units NovoLog administered at 6:00 p.m., meal intake records identified the resident refused her evening meal. Although meal intake records identified Resident #21 failed to consume 50% of her meals on the above seven occasions, the MAR identified staff administered 25 units of NovoLog, which may have resulted in unstable blood sugar levels. PRN MEDICATION FOLLOW-UP 2. Based on record review, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to ensure staff reassessed the response to as needed (PRN) pain medications in a timely manner for 5 of 23 sampled residents (Resident #7, #8, #9, #11, and #12) identified with orders for PRN pain medications. Failure to timely reassess after administering a PRN pain medication limits staff's ability to assess the effectiveness of the pain medication and may result in the resident experiencing unrelieved pain.	F 281	ensure timely follow-up. The Quality Coordinator will report the results of the audits monthly at the QAPI team meetings. The need for further audits will be determined at the discretion of the QAPI team.	

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F 281	Continued From page 5 Findings include: "Nursing 2015 Drug Handbook," 35th edition, Wolters and Kluwer, Pennsylvania, stated the following: * Page 74-76: ". . . acetaminophen [Tylenol] . . . Analgesic . . . peak [highest level of pain relief at] 1/2 - 2 hr [hour] . . ." * Page 971-972: ". . . morphine . . . opioid analgesic . . . peak 1 - 2 hr . . ." * Page 1071: ". . . oxycodone . . . opioid analgesic . . . peak 1 - 2 hr . . ." * Page 1407: ". . . Tramadol . . . Analgesic . . . peak 2 hr . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1106, 1109, and 1121, states, ". . . NONOPOID ANALGESICS/NSAIDS [nonsteroidal anti-inflammatory drugs] FOR MILD PAIN - *Acetaminophen (Tylenol . . .) *Ibuprofen . . . OPIOID ANALGESICS FOR MODERATE PAIN - *Tramadol . . . OPIOID ANALGESICS FOR SEVERE PAIN . . . *Oxycodone . . . Morphine sulfate . . . NURSING RESPONSIBILITIES *Assess pain prior to and 60 minutes after administration. . . . Evaluate the effectiveness of pain control measures used through ongoing assessment. . . ." Review of the facility policy titled "Medication Administration" occurred on 11/16/16. This policy, revised May 2015, stated, " . . . All PRN medications given should have a reason for giving and outcome recorded in the eMAR [electronic medication administration record]. As	F 281		

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nursing assessment indicates, documentation is placed in the Progress Notes concerning reasons for giving and the effect of the medication. . . ."

Review of the facility policy titled "Pain Management" occurred on 11/16/16. This policy, revised June 2012, stated, " . . . Purpose . . . To provide guidelines for assessment, protocols for interventions, and criteria for evaluation of resident outcomes related to pain management . . . Assessment and intervention should continue until pain is resolved or at the acceptable level for the resident . . ."

- Review of Resident #11's medical record occurred on November 15-16, 2016. Diagnoses included Alzheimer's disease, dependence on oxygen, chronic obstructive pulmonary disease, dementia, and acute respiratory failure. A re-entry Minimum Data Set (MDS), dated 09/19/16, identified severely impaired cognition and presence of occasional pain rated at a 5 on a scale from 0 to 10. The current care plan stated, "Focus . . . I have acute pain r/t [related to] Emotional distress of progression of COPD [chronic obstructive pulmonary disease] . . . Interventions . . . Notify MD/NP [doctor of medicine/nurse practitioner] if interventions are unsuccessful . . ."

PRN medications included:
* Acetaminophen 325 milligrams (mg) give 650 mg every 6 hours as needed for pain. Review of the eMAR and progress notes for September and October 2016 showed acetaminophen administered 21 times with reassessment on 14 occasions occurring over 2 to 14 hours later.
* Oxycodone 5 mg-Acetaminophen 325 mg give

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1 tablet every 4 hours as needed for pain. Review of the eMAR and progress notes for September and October 2016 showed Oxycodone 5 mg-Acetaminophen 325 mg administered 10 times with reassessment on 6 occasions occurring over 2 to 6 hours later.
* Morphine 5 mg every 6 hours as needed for pain/shortness of breath. Review of the eMAR and progress notes for October 2016 showed morphine administered 21 times with reassessment on 9 occasions occurring over 3 to 9 hours later.

- Review of Resident #12's medical record occurred on November 15-16, 2016. Diagnoses included osteoarthritis, paranoid schizophrenia, myalgia, urinary tract infections, and compression fracture of the back. A quarterly MDS, dated 10/17/16, identified frequent pain rated at a 5 on a scale from 0 to 10. The current care plan stated, "Focus . . . I am on pain medication therapy r/t disease process (DJD, Arthritis) [degenerative joint disease] . . . Interventions . . . Observation/document side effects and effectiveness . . ."

PRN medications included Tramadol 50 mg every 8 hours as needed for pain. Review of the eMAR and progress notes for September 2016 showed Tramadol administered 16 times with reassessment on 11 occasions occurring over 2 to 11 hours later.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, pressure ulcer, and dementia. The current care plan stated, "I have a history of chronic pain . . . Identify

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previous response to analgesia including pain relief, side effects and impact on function. . . ."

PRN medication included Tylenol 650 mg every 4 hours for headache/pain. Review of the eMAR and progress notes for August and November 2016 showed Tylenol administered 2 times with reassessment occurring 3 to 5 hours later.

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia, and history of pressure ulcers. The current care plan stated, "Alteration in comfort . . . Use pain management as appropriate. Observe/document side effects and effectiveness. . . ."

PRN medication included Tylenol 650 mg every 6 hours for pain. Review of the eMAR and progress notes for October and November 2016 showed Tylenol administered 5 times with reassessment on 1 occasion occurring over 3 hours later.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included chronic pain, polyosteoarthritis, and dementia. The current care plan stated, "I have an alteration in comfort manifested by pain related to severe arthritis, peripheral neuropathy and restless leg syndrome . . . Anticipate my need for pain relief and respond immediately to any complaints of pain . . . Observe/document for side effects of pain medication . . . Observe/record/report any signs/symptoms of non-verbal pain. . . ."

PRN medication included Ibuprofen 200 mg every 6 hours for pain. Review of the eMAR and

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F 281	Continued From page 9 progress notes for November 2016 showed Ibuprofen administered 8 times with reassessment on 1 occasion occurring 5 hours later with a pain level of 7 documented. During an interview on 11/16/16 at 9:00 a.m., an administrative nurse (#9) confirmed staff are required to follow up within 2 hours regarding the effectiveness of the analgesic administered.	F 281		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide fluids to maintain proper hydration for 3 of 11 sampled residents (Resident #10, #12, and #15) who require staff assistance for fluid intake. Failure to provide assistance/encouragement with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: - Review of Resident #15's medical record occurred on November 14-16, 2016. The current Minimum Data Set (MDS), dated 09/29/16, identified severe cognitive impairment and extensive assistance from one person for eating. Resident #15's current care plan stated, ". . . I am at risk for dehydration or potential fluid deficit r/t [related to] suboptimal intake. . . . Interventions . .	F 327	1. Residents #10, #12, and #15 have been assessed for dehydration risk by the dietitian (LRD). 2. All residents have the potential to be affected. 3. A communication was sent out to nursing staff on November 23 and an in-service for LNs and CNAs will be held on December 14 to discuss the need to offer fluids with resident interactions. 4. A minimum of five random dining room observation audits will be completed weekly by the LRD for one month followed by two audits per week for three months. The LRD will report the audit results to the DONS and each month at the monthly QAPI team meeting. The CNA mentors will complete a minimum of twenty-five random observations of	12/21/16

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F 327	Continued From page 10 . Assist me with access to a variety of fluids whenever possible. . . . I need assistance/encouragement and supervision with fluid intake in order to meet daily requirements. . . ." A nurse's note, dated 09/29/16, stated, ". . . Staff has resident up on commode this am [morning] and she was unable to pass all her stool by herself and was complaining of pain. Staff laid resident in bed and nurse was able to manually assist with stool extraction. Resident stated she was greatly relieved after this. Staff will encourage more fluid intake. . . ." Observation on 11/14/16 at 8:30 a.m. showed Resident #15 in bed until 10:52 a.m., when two certified nursing assistants (CNAs) (#1 and #2) assisted her out of bed. The CNAs failed to offer/encourage fluid intake during cares. Observation on 11/15/16 at 9:09 a.m. showed Resident #15 in bed until 11:02 a.m., when two CNAs (#3 and #4) assisted her out of bed. The CNAs failed to offer/encourage fluid intake during cares. - Review of Resident #10's medical record occurred on November 14-16, 2016. The quarterly MDS, dated 09/16/16, identified severe cognitive impairment and extensive assistance from one person for eating. Resident #10's current care plan stated, "Focus . . . I need help with my ADL's [activities of daily living] self-care performance deficit . . . EATING: I require assist of 1, I can usually start eating myself but need staff to assist as I forget . . . Encourage me to have adequate fluid intake . . ."	F 327	offering fluids with cares while in resident rooms daily for five days. The Staff Development RN will be responsible to complete a minimum of twenty-five observations weekly for three weeks, then twenty-five observations monthly for the next eleven months. The results of the audits will be reported to the DONS who will report monthly at the QAPI team. The need for further audits will be determined at the discretion of the QAPI team.	

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F 327	Continued From page 11 Observation on 11/14/16 at 11:15 a.m. showed Resident #10 sat in her wheel chair in the dining room and attempted to feed herself with a fork. At 12:05 p.m., the CNA (#12) removed Resident #10 from the dining room and brought her back to her room. A cup of coffee, a small glass of cranberry juice, and a glass of water remained untouched. The CNA failed to offer/encourage fluid intake. Observation on 11/14/16 at 1:00 p.m., showed the CNA (#12) assisted Resident #10 with toileting cares. The CNA failed to offer/encourage fluid intake with cares. - Review of Resident #12's medical record occurred on November 15-16, 2016. Diagnoses included constipation, and urinary tract infections. The current care plan stated, "Focus . . . I have . . . History of UTI . . Interventions . . . Encourage me to consume adequate fluids during the day . . ." Observation on 11/14/16 at 11:20 a.m. showed Resident #12 sat at the dining room table with her lunch in front of her. An unidentified staff member sat at the same table and assisted another resident with her lunch. At 11:30 a.m. Resident #12 pushed herself away from the dining room table and a CNA (#2) assisted the resident back to her room. A container of ensure (supplement), a glass of juice, and a glass of water remained untouched. Both staff members (unidentified and #2) failed to offer/encourage fluid intake during the meal. Observation on 11/14/16 at 12:00 p.m. showed a	F 327		

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F 327	Continued From page 12 CNA (#2) assisted Resident #12 with personal cares and onto the bed. The CNA failed to offer/encourage fluid intake with cares. Observation on 11/14/16 at 3:30 p.m. showed a CNA (#13) assisted Resident #12 with personal cares and back to her bed. Two boxes of unopened ensure remained on the bedside table. The CNA failed to offer/encourage fluid intake with cares. During an interview on 11/16/16 at 9:00 a.m., an administrative nurse (#9) confirmed staff should offer fluids with cares and during meals.	F 327		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		12/21/16

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F 329	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 5 of 9 sampled residents (Resident #11, #13, #15, #20, and #24) who received as needed (PRN) psychotropic medications. Failure to determine the necessity of a medication prior to administration placed residents at risk of receiving unnecessary medications and suffering adverse consequences related to their use. Findings include: - Review of Resident #13's medical record occurred on November 14-16, 2016. Diagnoses included dementia and anxiety disorder. The current Minimum Data Set (MDS), dated 10/30/16, identifed severe cognitive impairment. Physician's orders included Ativan (an anti-anxiety medication) 0.5 milligrams (mg) every 6 hours PRN. Review of Resident #13's medication administration records (MARs) for September 1, 2016 through November 15, 2016 identified staff administered PRN Ativan on 15 occasions. The record lacked evidence of non-pharmacological interventions attempted prior to administering the Ativan on 13 occasions. - Review of Resident #15's medical record	F 329	1. Residents #11, #13, #15, #20, #24, care plans were reviewed and individualized by the RN Care Coordinators to identify non-pharmacological interventions to use prior to administration of PRN psychotropic medications. 2. All residents receiving PRN psychotropic medications have the potential to be affected. 3. A communication was sent out to nursing staff on November 23 and an inservice for LNs and CNAs will be held on December 14 in regards to the use of PRN psychotropic medications and non-pharmacological interventions. 4. The Quality Coordinator, or designee, will complete a minimum of five random audits of PRN pain medication administration each week for one month, then ten audits monthly for eleven months ensure proper non-pharmacological interventions are attempted prior to administration. The results of the audits will be reported to the QAPI team. The need for further audits will be determined at the discretion of the QAPI team.	

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F 329	Continued From page 14	F 329		

occurred on November 14-16, 2016. Diagnoses included dementia. The current MDS, dated 09/29/16, identified severe cognitive impairment. Physician's orders included Ativan 0.25 milligrams (mg) every 12 hours PRN. Resident #15's current care plan lacked information related to anxiety as well as individualized non-pharmacological interventions.

Review of Resident #15's MARs for September 22, 2016 through November 15, 2016 identified staff administered PRN Ativan on 14 occasions. The record lacked evidence of non-pharmacological interventions attempted prior to administering the Ativan on 13 occasions.

- Review of Resident #20's medical record occurred on November 15-16, 2016. Diagnoses included Alzheimer's, depression, and dementia. A quarterly MDS, dated 10/08/16, identified severely impaired cognition.

Resident #20's November 01-16, 2016 MAR identified Ativan 0.5 mg by mouth every 6 hours as needed for anxiety and administered six times. Review of progress notes identified staff administered the medication for increased anxiety, restlessness, confusion, and "to see if helps with sleep." The record lacked documentation of non-pharmacological interventions tried before administrating PRN Ativan.

- Review of Resident #24's medical record occurred on November 15-16, 2016. Diagnoses included anxiety, dementia, and depression. An admission MDS, dated 10/05/16, identified severely impaired cognition.

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F 329	Continued From page 15 Resident #24's November 01-16, 2016 MAR identified Ativan 0.25 mg by mouth every 8 hours as needed for anxiety and administered five times. Review of progress notes identified staff administered the medication three times for increased anxiety and restlessness. The record lacked documentation of non-pharmacological interventions tried before administrating PRN Ativan. - Review of Resident #11's medical record occurred on November 15-16, 2016. Diagnoses included Alzheimer's, dependence on oxygen, chronic obstructive pulmonary disease, depression, dementia, and acute respiratory failure. A re-entry MDS, dated 09/19/16, identified severely impaired cognition. Physician's orders included Lorazepam (Ativan) (an anti-anxiety medication) 0.5 milligrams (mg) give 1 every 4 hours as needed for anxiety. Resident #11's medication administration records for September 1, 2016 through October 31, 2016 identified staff administered PRN Ativan on 41 occasions. The record lacked evidence of non-pharmacological interventions attempted prior to administering the Ativan on 39 occasions. During an interview on 11/16/16 at 9:00 a.m., an administrative nurse (#9) confirmed staff are required to attempt and document non-pharmacological interventions prior to PRN Ativan administration.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		12/21/16

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F 431	Continued From page 16 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to properly store and label medications in 2 of 10 medication	F 431	1. Unlabeled or expired insulin vials were replaced and dated with both the open date and the expiration date.	

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F 431	Continued From page 17 carts (Valley Transitions and Riverside). Failure to ensure insulin vials are clearly marked with the date opened, and discarded when expired, increased the risk of residents receiving medication with reduced efficacy. Findings include: Review of the facility policy titled "Pharmacy Policy and Procedure" occurred on 11/15/16. This policy, revised March 2013, stated, ". . . 12. A bottle of insulin in current use (i.e., [for example] will be used up within 30 days), may be stored with other resident medications in current use. . . . B. Expiration Dating 1. Medication shall not be kept on hand beyond their indicated date of expiration. When the expiration date is reached, such mediations [sic] shall be removed, destroyed. . . ." Observation on 11/15/16 at 9:35 a.m. of the medication cart for the back hall of the Valley Transitions unit showed one vial of NovoLog insulin and two vials of Lantus insulin in use with no opened date identified. The staff nurse (#10) stated the vials should have been marked with the date opened. Observation on 11/15/16 at 10:55 a.m. of the medication cart for the front hall of the Riverside unit showed one vial of Lantus and one vial of NovoLog insulin marked as opened on 10/06/16. The staff nurse (#11) stated these insulin vials expired on 11/03/16, 28 days after the opened date, and the night nurse should have checked the expiration date and removed the vials from use. Further observation showed an unreadable opened date on a vial of NovoLog insulin. The	F 431	2. All residents who are receiving insulin have the potential to be affected by this area. 3. A communication was sent out to nursing staff on November 23 and an inservice for LNs will be provided on December 14 to Licensed Nurses with educational material regarding insulin storage, expiration, and labeling. 4. Each night charge nurse will audit insulin for expiration dates, open dates and legibility of labels on a weekly basis for one year of all insulin vials and pens. The audit results will be reported by the DONS at the monthly QAPI team meeting. Audit results will be reviewed monthly by the QAPI team. The need for further audits will be determined at the discretion of the QAPI team.	

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F 431	Continued From page 18 nurse (#11) verified the date as unreadable. During an interview on 11/15/16 at 11:10 a.m. a charge nurse (#12) stated nurses should use the round stickers to write the opened date and expiration date on all insulin vials.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		12/22/16

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F 441	Continued From page 19 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 5 of 14 sampled residents (Resident #1, #2, #3, #10, and #18) observed during personal cares. Failure to remove gloves and perform hand hygiene after going from a contaminated body site to a clean body site and after providing perineal cares to residents may contribute to the spread of infection. Findings include: Review of the facility policy titled, "Hand Washing" occurred on 11/16/16. This policy, revised February 2015, stated, "I. Policy. Hand washing shall be regarded by this organization as the single most important means of preventing the spread of infections. II. Procedure. Q. All personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, residents, and visitors. . . . C. Hand Hygiene must be performed under the following conditions: . . . 4. Before and after handling clean or soiled dressings, gauze pads, etc.; . . . 6. Before and after direct resident contact; 7. Decontaminate hands if moving from a	F 441	1. The CNAs that were working with the identified residents during the survey were conferenced and reeducated by the Staff Development RN. Nurse #8 was educated on wound care and catheter care by the Staff Development RN. 2. All residents have the potential to be affected. 3. A communication was sent out to nursing staff on November 23 and an inservice for LNs and CNAs will be held on December 14 in regards to appropriate hand hygiene techniques. All CNAs are audited for appropriate infection control techniques upon hire and annually. 4. The CNA mentors will complete a minimum of twenty-five random observations of proper hand hygiene daily for five days. The Staff Development RN will be responsible to complete a minimum of twenty observations weekly for three weeks, then twenty observations monthly for the next eleven months. Starting December 22, the Staff Development RN will complete a minimum of three random observations of licensed nurses providing proper wound care and three observations of licensed	

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F 441	Continued From page 20 contaminated-body site to a clean-body site during resident care; 8. After contact with blood, body fluids, excretions, secretions, mucous membranes, or non-intact skin; 9. After handling items potentially contaminated with blood, body fluids, excretions, or sections; 10. After removing gloves; . . . E. The use of gloves does not replace hand washing. . . ." - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included osteomyelitis and methicillin resistant staphylococcus aureus (MRSA) (a type of bacteria resistant to many antibiotics) infection in left lower extremity. Resident #18 currently receives intravenous antibiotics for MRSA and osteomyelitis, and staff follow contact precautions when completing dressing changes to the wound. Observation of a nurse providing wound care to Resident #18's left leg occurred on 11/14/16 at 8:50 a.m. The nurse (#8), wearing a gown and gloves, cleansed Resident #18's leg with a Hibiclens solution. Observation showed areas of weeping skin on the thigh and shin/calf and open areas on the top of the toes and lateral foot. After cleansing the skin, the nurse removed her gloves, applied new gloves, applied dressings to the tops of the toes, wrapped the toes with lambswool, applied a dressing to the wound on the lower lateral foot, and applied a large absorbent dressing to the weeping areas of skin on the resident's shin. The nurse removed her gloves, donned new gloves, unclamped the drain tubing on Resident #18's urinary catheter bag and administered odor eliminator drops to the bag. The nurse then wiped the end of the catheter tubing with an alcohol swab, clamped	F 441	nurses providing proper catheter care daily for five days. The Staff Development RN will be responsible to complete a minimum of five observations of wound care and five observations of catheter care weekly for three weeks, and complete five observations of wound care and five observations of catheter care monthly for the next eleven months. The results of the audits will be reported to the DONS who will report monthly at the QAPI team. The need for further audits will be determined at the discretion of the QAPI team.	

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F 441	Continued From page 21 the end, and removed her gloves. The nurse failed to perform hand hygiene after providing care for Resident #18's wounds and before performing cares with the resident's urinary catheter. Failure to perform hand hygiene after cleansing/dressing an infected wound and before performing a task on a clean body site has the potential to result in the spread of infection. - Review of Resident #10's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 09/16/16, identified severe cognitive impairment and extensive assistance from one person for personal cares and toileting. Observation on 11/14/16 at 12:05 p.m., showed a certified nursing assistant (CNA) (#12) assisting Resident #10 with toileting cares. The CNA (#12) donned gloves and wiped Resident #10's perineal area from front to back with disposable wipes. There was visible stool on the wipes. The CNA (#12) applied cream to the perineal area, placed a clean brief, pulled up her pants, adjusted her clothing, and assisted her into the wheel chair, then removed the gloves. The CNA (#12) applied clean gloves, wiped off the toilet seat with a disposable wipe, and removed her gloves. With her right hand, the CNA (#12) brushed Resident #10's hair away from her eyes and the side of her face, gave her a hug, and then pushed the resident in the wheel chair out of the bathroom. The CNA (#12) failed to complete hand hygiene after performing perineal cares, wiping off the toilet seat, and prior to completing other cares/tasks.	F 441		

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- Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 08/29/16, identified intact cognition and limited-to-extensive assistance required from one person for transfers and toileting.

Observation on 11/14/16 at 9:30 a.m., showed two CNAs (#16 and #17) assisted Resident #3 with personal cares. The CNA (#16) donned gloves, removed soiled linen, emptied a basin (the resident used to brush her teeth), removed her gloves, and assisted the resident with other cares. The CNA (#16) failed to complete hand hygiene after completing the resident's morning cares. Resident #3 then transferred herself into the bathroom and onto the toilet. The CNA (#16) donned a new pair of gloves, removed the resident's pajamas, covered her with a gown (that opened in the back), and cued the resident to stand-pivot into her wheelchair. The CNA (#16) failed to cover Resident #3's wheelchair cushion before allowing her to sit in the chair unclothed from the waist down.

- Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 10/13/16, identified moderately impaired cognition and extensive assistance required from one person for toileting and personal hygiene.

Observation on 11/14/16 at 11:21 a.m., showed a CNA (#19) assisted Resident #2 with personal cares. The CNA (#19) donned gloves, strapped Resident #2's catheter bag to her right leg, removed his gloves, brushed the resident's hair, attached the foot pedals to her wheelchair, and transported her to an appointment. The CNA

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(#19) failed to complete hand hygiene after completing the resident's personal cares and prior to exiting the room.

- Review of Resident #1's medical record occurred on all days of survey. The quarterly MDS, dated 08/13/16, identified moderately impaired cognition and extensive assistance required from two persons for toileting and personal hygiene.

Observation on 11/15/16 at 8:08 a.m., showed two CNAa (#18 and #20) repositioned Resident #1 in her wheelchair utilizing a full body lift. One of the CNAs (#18) donned gloves, removed the resident's lap tray and positioning pillows, attached the sling to the lift, raised the lift, repositioned Resident #1, lowered the lift, removed the sling/lift, and removed her gloves. The CNA (#18) failed to complete hand hygiene after completing the resident's personal cares and prior to exiting room.

During an interview on 11/16/16 at 9:00 a.m., an administrative nurse (#9) confirmed staff should wash their hands after removing gloves, after completing perineal cares, and prior to completing other cares/tasks.