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	355067	A. BUILDING _____ B. WING _____	02/08/2018

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 The standard Medicare/Medicaid recertification survey started on 02/05/18 and concluded on 02/08/18.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/18/18

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

Electronically Signed | 03/12/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to serve all residents seated at the same table at one time for 2 of 2 meals observed (the evening meal on 02/05/18 and the noon meal on 02/06/18). Failure to serve all residents at the same table at once does not enhance residents' dignity or quality of life. Findings include: Observation on 02/05/18 at 6:11 p.m., showed two residents at table nine served their meals while the other two residents waited to be served. Resident #165 was served his meal at 6:25 p.m., followed by Resident #23 at 6:26 p.m.. Observation on 02/06/18 at 12:06 p.m., showed one resident served his/her meal while the other two residents at the same table waited until 12:13 p.m. to receive their meals. Observation of the noon meal on 02/06/18 showed the following: *At 11:55 a.m.: Resident #154 sat at the table with two other residents, who had begun eating their food. *At 12:08 p.m.: One tablemate stated, "I wonder	F 550	Residents #23 and #154 were interviewed on 3/5/18 and Resident #165 was interviewed on 3/8/18 about any issues related to dining service and specifically about whether they are served at the same time as their other tablemates. None of the residents had any concerns related to dining services. All residents that eat in dining rooms have the potential to be affected by the practice of not being served at the same time. It is the standard of Dining Services to serve all residents who are seated at a table at the same time. Dining Services staff were reeducated on various dates in February and March and they signed a written reminder on the process to ensure that residents are served as soon as possible so residents can eat together at the same table. Nurses and CNAs will be reeducated on 3/13/18 to 3/16/18 to notify the dining services staff when a resident does not receive their food at the same time or arrives later than their tablemates who were already served. The meals will be served as soon as possible after the next complete table is served. This	

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F 550	Continued From page 2 where your food is?" Resident #154 responded, "I don't know." The other tablemate asked a staff member, "Where is his food?" *At 12:12 p.m.: Staff served Resident #154 his meal, and observation showed his tablemates were done eating. During an interview on 02/06/18 at 5:40 p.m., Resident #154 stated he often has to wait for meals and "They [the meals] don't come quickly." The resident stated everyone at his table doesn't always eat at the same time, even if the residents are all there at the same time. During an interview on 02/07/18 at 11:30 a.m. a dietary manager (#2) stated staff should serve all residents at the table at the same time. If the resident arrived later than other residents, kitchen staff should be alerted, and the resident should receive their meal right away.	F 550	standard was discussed in Resident Council on 3/9/18. The Director of Dining Services is responsible to complete five dining room audits per week starting on 3/5/18 for three months specific to serving residents in a timely manner at the same table. The Director of Dining Services will bring the results of the audits to the VEC Quality Review Team meeting on a monthly basis and will reevaluate the frequency of the audits after three months. Audits will continue for the remainder of the year but the frequency may be decreased based on compliance with the standard.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 35 sampled residents (Resident #75 and #148). Failure to accurately complete Section I (Active Diagnoses) and Section N (Medications) of the MDS does not allow each resident's assessment to reflect	F 641	Resident #75 was reassessed on 2/6/18 and the quarterly MDS dated 12/7/17 was modified to remove the diagnosis of pneumonia in Section I. Resident #148 was reassessed on 2/9/18 and the MDS dated 1/16/18 was modified to correct the number of days the resident received antidepressants, anticoagulants and also diuretics in Section N. The modifications of the two incorrect MDS assessments	3/18/18

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F 641	Continued From page 3 their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2017, page I-3 stated, ". . . DEFINITIONS . . . ACTIVE DIAGNOSES . . . Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. . . ." Review of Resident #75's current MDS, dated 12/07/17, identified Pneumonia coded under section I2000. The resident's record lacked evidence of a pneumonia diagnosis during the look-back period. During an interview on 02/07/18 at 8:22 a.m., a supervisory nursing staff member (#9) stated she did not have further information regarding a pneumonia diagnosis and planned to complete a modification of the MDS. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2017, page N-7 stated, ". . . N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day	F 641	were submitted and accepted by both CMS and state agencies. All residents have a potential to have an inaccurate MDS for if medications are counted incorrectly for Section N or if residents have a resolved diagnosis that remains active in Section I. All RN Care Coordinators were provided additional education on MDS sections I and N through Healthcare Academy by 2/28/18. All resident diagnosis lists were reviewed and updated by the Coding Specialist for Valley Memorial Homes by 2/19/18 to reflect any diagnoses that may have resolved or are no longer active. All of the most recent MDS assessments completed in the facility were audited to ensure accuracy in Sections I & N. Identified errors were corrected and a modification was completed as of 3/12/18. The Director of Nursing Services (DONS) or designee will complete a minimum of ten weekly MDS audits of sections I and N for four consecutive weeks beginning 3/12/18. Upon completion of four weeks, ten audits per month will be completed by the DONS or designee for the next eleven months. All MDS assessments found to be out of compliance will be modified and submitted. Upon identification of any discrepancies, the RN Care Coordinator will be provided with additional education by the DONS. The DONS will submit the results of the audits to the VEC Quality Review Team monthly for the next twelve	

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F 641	Continued From page 4 look-back period (or since admission/entry or reentry if less than 7 days) . . . N0410E, Anticoagulant (e.g. [example given], warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . . . N410G, Diuretic: Record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). - Review of Resident #148's medical record occurred on all days of survey. Review of the resident's quarterly MDS, dated 01/16/18, and the January 2018 electronic medication administration record (eMAR) showed the following: * The MDS N0410C coded as 5 indicating the resident received an antidepressant on five days during the 7-day look-back period. The eMAR identified an antidepressant administered on four days of the look-back period * The MDS N0410E coded as 4 indicating the resident received an anticoagulant on four days during the 7-day look-back period. The eMAR identified an anticoagulant administered on five days of the look-back period * The MDS N0410G coded as 5 indicating the resident received a diuretic on five days during the 7-day look-back period. The eMAR identified a diuretic administered on four days during the look-back period. During an interview on the afternoon of 02/07/18, an MDS Coordinator agreed she failed to code the above sections of the MDS correctly.	F 641	months.	

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F 641	Continued From page 5 Section I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2017, page I-3 stated, ". . . DEFINITIONS . . . ACTIVE DIAGNOSES . . . Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. . . ." Review of Resident #75's current MDS, dated 12/07/17, identified Pneumonia coded under section I2000. The resident's record lacked evidence of a pneumonia diagnosis during the look back period. During an interview on 02/07/18 at 8:22 a.m., a supervisory nursing staff member (#9) stated she did not have further information regarding a pneumonia diagnosis and plans to complete a modification of the MDS.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		3/18/18

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F 644	Continued From page 6 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures For Long Term Care Services, and interview with an Ascend (the state-designated authority) representative, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #96) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASRR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC])	F 644	A new Pre-Admission Screening and Resident Review (PASARR) Level I screening was completed for Resident #96 on 02/08/18 with response and approval from Ascend on 02/09/18. The Ascend reviewer concluded that a Level II screening was not required. All residents with a mental health diagnosis have the potential to be affected by not completing a Level I status change assessment. In order to prevent future occurrences, the coding specialist will report any new mental health diagnoses to Social Services. Social Services will complete a review of all current residents with a mental illness diagnosis and cross reference the resident□s most recent Level I PASRR screening to ensure all existing mental health diagnoses are included. Any resident whose Level I screen does not reflect an existing mental health diagnosis will have a new Level I submitted to include all current diagnosis by 3/15/18. Starting on 3/16/18, Social Services will be responsible to audit the active	

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F 644	Continued From page 7 was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #96's medical record occurred on February 7-8, 2018. The record showed an initial PASRR completed on 12/20/16 and identified a diagnosis of dementia and no mental illness. A psychiatric progress note, dated 05/16/17, identified a diagnosis of unspecified psychotic disorder. The record lacked evidence of an updated Level I screening/change in status assessment since this diagnosis. During a phone interview on the afternoon of 02/23/18, an Ascend nurse reviewer stated unspecified psychosis is a major mental illness; and after the resident received that diagnosis, a change in status form should have been completed, regardless of a dementia diagnosis.	F 644	diagnosis list of their residents upon completion of Admission, Quarterly and Annual MDSs for the next twelve months to cross reference with the most recent Level I screening to ensure all existing diagnoses are reflected in the screening. If a new diagnosis is identified, an updated PASRR will be completed at that time. The Director of Social Services will submit the results of the audits to the VEC Quality Review Team monthly for the next twelve months.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (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).	F 657		3/18/18

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F 657	Continued From page 8 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 observation, record review, policy and procedure review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 4 of 37 sampled residents (Resident #49, #142, #148, and #151). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Interdisciplinary Care Plan" occurred on 02/08/18. This policy, dated March 2017, stated, "I. Policy - A comprehensive care plan must be developed and implemented for each resident, consistent with the resident's rights. The comprehensive care plan must include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that re (sic) identified in the comprehensive assessment. II. Procedure A. The comprehensive care plan must describe the following: 1. Services that are to be furnished to	F 657	Resident #142□s care plan was updated on 2/8/18 to reflect the route of administration for the nutritional supplement. Resident #148□s care plan was updated to reflect the risk for falls due to the oxygen tubing that the resident uses. Resident #49 and #151□s care plans were updated to reflect the addition of a treatment for an active skin impairment. All residents have the potential to be affected by care plans that are not current to resident care. Licensed Nurses will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will provide additional education on updating the care plan for accuracy. The RN Care Coordinator will audit all care plans for residents with oxygen tubing, active skin impairments, and enteral feeding tubes by 3/15/18.	

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F 657	Continued From page 9 attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. . . . D. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. . . ." - Review of Resident #49's medical record occurred February 7-8, 2018. Diagnoses included vascular dementia without behavioral disturbance, pain, and edema. A quarterly Minimum Data Set (MDS), dated 11/22/17, identified Resident #49 as cognitively intact, required pressure ulcer care, and a pressure reducing device for chair and bed. A skin and wound assessment, dated 02/07/18, identified a stage 2 facility aquired pressure ulcer to the left heel on 12/04/17. Resident #49's care plan stated, ". . . risk for skin breakdown r/t [related to] my impaired mobility, edema, and incontinence. 5/22/17 hospital return with STdi [suspected tissue deep injury] to left heel. . . . weekly treatment documentation to include measurement of each area of skin breakdown; width, length, depth, type of tissue and exudate and any other notable changes or observations. . . ." Facility staff failed to address Resident #49's current pressure ulcer by implementing interventions to heal the ulcer and failed to develop measures to prevent future pressure ulcers. - Review of Resident #151's medical record occurred on February 7-8, 2018. Diagnoses	F 657	It is the responsibility of the Staff Development RN or designee to conduct 10 audits per week to resident care plans and accuracy over the next four weeks beginning 3/12/18. This audit will focus on residents with skin treatments, enteral feeding tubes, and oxygen tubing in relation to fall risk. This will be completed by reviewing the resident□s care plan, assignment sheet and the medical record and comparing to ensure consistency. Upon completion of the fourth week, 10 audits will be completed each month by the Staff Development RN or designee for the next 11 months. The Staff Development RN is responsible to bring the results of the audits to the VEC Quality Review Team on a monthly basis for 12 months.	

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included pressure ulcer of sacral region stage 2, pressure ulcer of left heel stage 2, and unspecified calorie malnutrition. An annual MDS, dated 01/17/18, identified Resident #151 as cognitively intact, required pressure ulcer care, pressure reducing device for chair and bed, a stage 3 pressure ulcer and unstageable deep tissue injury.

Resident #151's care plan occurred on February 7-8, 2018. This care plan stated, ". . . potential for skin breakdown and actual skin integrity impairment r/t impaired mobility, incontinence, surgical wound, post op [operation] anemia, malnutrition (low albumin), and edema. . . . encourage good nutrition and hydration in order to promote healthier skin. . . . TX [treatment] as directed to bottom. See TAR [treatment administration record] for current TX orders. . . ."

Facility staff failed to address the Resident #151's current pressure ulcers by implementing interventions to heal the ulcers and failed to develop measures to prevent future pressure ulcers.

During an interview on 02/07/18 at 1:39 p.m., an administrative staff member (#1), verified the care plans for Resident #49 and #151 lacked information regarding pressure ulcers.

- Review of Resident #142's medical record occurred on all days of survey. Diagnoses included dysphagia, dementia, weakness, gastro-esophageal reflux disease (GERD) without esophagitis, hemiplegia and hemiparesis. A quarterly MDS, dated 01/14/18, identified Resident #142's swallowing/nutritional status as

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F 657	Continued From page 11	F 657		

receives 51% or more of her total calories through tube feedings.

Review of Resident #142's care plan occurred on February 7-8, 2018. This care plan stated, ". . . I have an activities of daily living (ADL) self-care performance deficit related to (r/t) Stroke, Dementia, Hemiplegia . . . EATING: . . . nothing by mouth (NPO), on tube feeding . . . I have GERD (r/t) hyperacidity . . . Dietary: encourage me to avoid foods or beverages that tend to irriate (sic) esophageal lining, i.e. alcohol, chocolate, caffeine, acidic or spicy foods, fried or fatty foods . . . Encourage me to avoid overeating. Provide small frequent meals rather that 3 large ones. Encourage me to take my time eating. Alternate food with sips of fluids. . . ."

Review of Resident #142's treatment administration record (TAR) occurred on all days of survey and stated, " . . . Enteral Feed Order three times a day check tube placement before initiation of formula . . . DO NOT CHECK RESIDUAL. . . ."

Review of Resident #142's care plan occurred on February 7-8, 2018. This care plan stated, " . . . I require tube feeding . . . Check for tube placement and gastric contents/residual volume per facility protocol and record. Notify MD/NP if unusual residual. . . ."

Facility staff failed to address Resident #142's current NPO status by implementing goals and interventions for proper care of her feeding tube.

During an interview on 02/08/18 at 7:58 a.m., two supervisory nurses (#9 and #10) verified the care

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F 657	Continued From page 12 plan for Resident #142 lacked updated information on her current NPO status. - Review of Resident 148's medical record occurred on all days of survey. Diagnoses included Chronic Obstructive Pulmonary Disease. Observation on February 5-7, 2018 showed Resident #148 had extended oxygen tubing lying across the floor in his room, posing a possible safety/fall hazard. Review of the current careplan failed to identify the extended oxygen tubing and possible safety/fall hazard. During an interview on the afternoon of 02/07/18, a supervisory nurse (#5), verified the care plan lacked interventions regarding the oxygen tubing length and resident safety. Failure to assess/evaluate need for extended oxygen tubing length and placement, placed Resident #148 at risk for possible falls and/or injury.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		3/18/18

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F 658	Continued From page 13 Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 sampled residents (Resident #184) observed during a pressure ulcer dressing change. Failure to follow physician's orders regarding dressing changes and failure to ensure accurate documentation may result in delayed assessment/treatment and worsening pressure ulcers. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . . Documentation . . . Nurses, therefore, need to provide accurate and complete documentation of the nursing care provided to clients. Failure to properly document can constitute negligence and be the basis for tort liability. Insufficient or inaccurate assessments and documentation can hinder proper diagnosis and treatment and result in injury to the client. . . ." Review of Resident #184's medical record occurred on all days of survey. Current diagnoses included a pressure ulcer to the left heel. Current physician's orders identified, "Left Heel; cleanse area, apply Medihoney to wound bed, cover with Aquacel foam; change QOD [every other day] . . ." During an interview on the afternoon of 02/05/18,	F 658	Resident #184□s dressing due on 2/5/18 was changed on 2/6/18. Nurse #15 will receive additional education and individual follow up specific to the dressing change by 3/16/18. Residents receiving physician ordered dressing treatments are at risk for this practice. Licensed Nurses will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will provide additional education on skin assessments and treatment which will include a demonstration of the appropriate documentation regarding dressing changes. It is the responsibility of the Staff Development RN or designee to perform a weekly audit for eight weeks starting on 3/12/18 for all residents with physician-ordered skin treatment dressings. The audit will address the consistency of the date of the dressing to the Treatment Administration Record and that the nurse who completed the dressing signed the order. Based on the results of the audit, the audits will be performed monthly for the next ten months. If any discrepancies are identified, the nurses involved will be provided additional education. The Staff Development RN will report the results of the audits to the VEC Quality Review Team for the next twelve months.	

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F 658	Continued From page 14 when asked if Resident #184 had any scheduled dressing changes, a staff nurse (#15) identified Resident #184 has a dressing change to his left heel, but she had not yet done it. She identified the staff on the next shift would do it. Observation on 02/06/18 9:53 a.m. showed a dressing in place to Resident #184's left heel with a date of 02/03/18 and a nurse's (#19) initials. A nurse (#16) changed the heel dressing and dated it 02/06/18. Observation also showed a dressing in place to the resident's coccyx area, with a date of 02/05/18 and a nurse's (#15) initials. Staff failed to change the heel dressing every other day as ordered. Resident #184's treatment administration record (TAR) identified heel, coccyx, and ischial dressing changes completed on 02/05/18. The TAR identified a nurse (#18) signed off these dressing changes; however, observation showed the heel dressing was dated 02/03/18 and contained another nurse's initials (#19), and the coccyx/ischial dressings in place (dated 02/05/18) were initialed by another nurse (#15). During an interview on the afternoon of 02/07/18, a supervisory nursing staff member (#9) stated she was unsure of the reason for the discrepancies.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		3/18/18

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F 684	Continued From page 15 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental and psychosocial well-being for 1 of 1 sampled resident (Resident #104) toileted with a full body mechanical lift who experienced unnecessary anxiety and pain during toileting. Failure to recognize and acknowledge Resident #104 was experiencing pain and address the underlying cause for her pain resulted in Resident #104's experiencing avoidable anxiety and pain while being toileted with a lift. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1035, states, ". . . Positioning a client in good body alignment and changing the position regularly and systematically are essential aspects of nursing practice . . . people who are weak, frail, in pain . . . rely on nurses to provide or assist with position changes . . . Any position, correct or incorrect, can be detrimental if maintained for a prolonged period. Frequent change of positions help to prevent muscle discomfort . . . When the client is not able to move independently or assist with moving, the preferred method is for two or more nurses to move or turn the client and use assistive	F 684	Resident #104 was reevaluated by Physical Therapy on 2/7/18 to determine the appropriateness of commode transfers. It was determined that this transfer method was appropriate for Resident #104. Staff who were identified to need follow up education received education by either the CNA Mentor or the Staff Development RN between 2/6/18 and 2/9/18. All residents in the facility utilizing a sling for total lift transfer have the potential to be affected by this practice. Licensed Nurses and CNAs will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will provide additional education to address identification and reporting of pain, proper positioning, hand hygiene related to glove use, proper brief removal for residents who use a toileting sling, and effective use of the walkie-talkie system. Effective 3/18/18, the orientation and annual training for CNAs will include additional education on positioning and transfers related to the total lift, hand hygiene related to glove use, identification and reporting of pain, and effective use of the walkie-talkie system. Effective 3/18/18, the orientation and annual	

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F 684	Continued From page 16 equipment. Appropriate assistance reduces the risk of muscle strain and body injury to both the client and nurse, and is likely to protect the dignity and comfort of the client. . . ." Review of Resident #104's medical record occurred on all days of the survey. Diagnoses included altered mental status, dementia, weakness and pain. The residents annual Minimum Data Set (MDS), dated 12/27/17, identified Resident #104 as being totally dependent with transfers, requiring extensive assistance with toileting (two plus), and receiving of scheduled and as needed (PRN) pain medications. The MDS further indicated Resident #104 has clear speech and responds adequately to simple, direct, communication. Resident #104's most recent care plan, stated, ". . . I require (total assistance) by (2) staff for toileting. I am checked and changed every 2 hours or PRN. I wear a medium brief for incontinence. I dribble urine and am incontinent of bowel. I am able to use the commode if I request . . . I require assistance by 1 staff to turn/roll side to side in bed . . . I have (Chronic) pain r/t left shoulder pain . . . Anticipate my need for pain relief and respond immediately to any complaints of pain . . . report any signs/symptoms (s/sx) of non-verbal pain: Changes in breathing (noisy,deep/shallow, labored, fast/slow; Vocalizations (grunting, moans, yelling out, silence); Mood/behavior changes (more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide, open/narrow slits/shut, glazed, tearing, no focus); Face (crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up,	F 684	training for nurses will include additional education on positioning and transfers related to the total lift, hand hygiene related to glove use, assessment of pain, and effective use of the walkie-talkie system. To monitor the effectiveness of these process changes, the Staff Development RN or designee is responsible to complete a CNA Resident Care Audit which evaluates positioning, transfers, hand hygiene, and walkie-talkie use among other items in the following situations for CNAs: before completion of orientation, upon completion of 90 days of employment, annually thereafter, and as needed. A minimum of 25 audits will be completed each month starting in March 2018. The Staff Development RN will report the results of these audits to the monthly VEC Quality Review Team meetings.	

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thrashing) . . . I do have a history of hollering out either my daughters name or making comments of " just take me now" when frustrated or in pain. . . I am usually . . . calm . . . I can answer you but am quite passive and content to let you take care of me. . . ."

Observation on 02/06/18 showed the following:
* 1:22 p.m.: A certified nursing assistant (CNA) (#12) transported Resident #104 to her room to perform toileting cares. Resident #104 stated, " I think I went in my pants." After retrieval of a sit to stand lift, the CNA (#12) waited for another staff member before transferring Resident #104 from her wheel chair (WC) to the commode. An unidentified CNA entered the room and stated, "This resident uses a Hoyer lift (a full body mechanical lift)."
* 1:30 p.m.: The unidentified CNA returned to the Resident #104's room with a full body mechanical lift.
* 1:35 p.m.: Both CNAs (#12 and unidentified) applied the toileting sling to the resident and raised the lift. Resident #104 was left suspended in the toileting sling for approximately 4 minutes while one of the CNAs (#12) positioned the commode under her and attempted to remove her brief which was soiled with bowel movement (BM). The CNA (#12) was unable to remove the soiled brief. She tore away the tabs on each side of the brief causing the back of the brief to fall into the commode.
* 1:39 p.m.: The unidentified CNA lowered Resident #104 onto the commode and exited the room. Resident #104 stated, "Right now this hurts me," as she sat at an angle on the commode, leaning back while her feet dangled in the air.

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F 684	Continued From page 18 * 1:44 p.m.: Resident #104 asked the CNA (#12), "Can you stand me up now? Please. I'm not ok. I'm uncomfortable. I am afraid I am going to fall out." Resident #104 had been improperly positioned on the commode for 6 minutes. * 1:45 p.m.: Resident #104 stated, "It hurts an awful lot. Please lift me up. Oh, how my legs hurt. I don't know how I'm going to be able to stand. My back, my back, how it hurts." The CNA (#12) emptied Resident #104's nephrostomy bag. Resident #104 grimaced and asked, "Can I get up now? You called a long time ago, and no one has come yet. Please call again." * 1:52 p.m.: In a weepy sounding voice Resident #104 asked the CNA (#12), "Can I get up now? You called a long time ago, and no one has come yet. Please call again." * 1:54 p.m.: Resident #104 yelled, "Why aren't they coming? I feel like I'm going to pass out." * 1:55 p.m.: A second CNA (#20) entered Resident #104's room. * 1:56 p.m.: Resident #104 cried, "Help! Help!" As one CNA (#20) raised the lift, the second CNA (#12) attempted to remove Resident #104's brief again by pulling it from the front, but she was unsuccessful. The CNA (#12) then stepped behind her and pulled the brief from the back, smearing BM across Resident #104's peri area. * 1:58 p.m.: As the CNA (#12) wiped the BM from her peri area, Resident #104 continued to cry and yell out in pain as she hung in the sling with her elbows elevated toward the ceiling. * 2:00 p.m.: The surveyor left the room in an effort to locate a staff nurse. Resident #104 had been hanging in the lift for 5 minutes. * 2:01 p.m.: A nurse (#11) entered Resident #104's room with the surveyor. Resident #104 continued to cry and yell out, " Let me down!" as	F 684		

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the CNA (#12) continued to clean the BM from her peri area.
* 2:02 p.m.: Both CNAs (#12 and #20) lowered Resident #104 onto the commode. She yelled, "I can't feel my ass, or arms and hands! Help me! Help me! Give me something to put me down! Give me something to put me down!" One of the CNAs (#20) commented, "Let's lay her down on the bed and finish cleaning her up there." Resident #104 had been suspended in the lift for 7 minutes. The other CNA (#20) then looked for a clean sheet and chux (disposable pad), but was unable to find either. She (#20) left the room to retrieve the items. Resident #104 continued to cry and yell as she sat on the commode, soiled with BM.
* 2:06 p.m.: After the CNAs (#12 and #20) had transferred Resident #104 from the commode to her bed, the nurse (#11) and one of the CNA (#20) exited the room. Resident #104 yelled, "My ass end hurts." The remaining CNA (#12) removed the toileting sling, catching the velcro in Resident #104's hair. She shouted, "Ouch. Ouch that hurt. Boy do I hurt? It hurts so much. My rear hurts so bad? It has never hurt like that before. Please be careful! It hurts so bad now." Resident #104 laid on her back in silence and appeared exhausted while the CNA (#12) retrieved cleansing wipes and a clean brief. Resident #104 stated, "It's burning! Please get me out! Can you give me a pill I can go out with?" The CNA (#12) did not respond to Resident #104's question. The CNA (#12) attempted to roll the resident onto her left side. Resident #104 grimaced and with tears on her face cried, "Ow, it hurts so bad. I can't lay on this side. Tell them I want a pill to go out. It hurts terrible. Please give me something. It hurts so bad. Please get my daughter in here."

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F 684	Continued From page 20 * 2:10 p.m.: The CNA (#12) was unable to roll the resident onto her left side and called for assistance. * 2:15 p.m.: The CNA (#12) called the nurse requesting Resident #104 be given something for pain. Resident #104 stated, "It hurts. I can't hear you. Please help me. It kills my ass and I can't hear what you are saying. Oh it hurts!" * 2:18 p.m.: A CNA mentor (#21) entered Resident #104's room and assisted the CNA (#12) to roll the resident onto her left side in order to continue cleansing her peri area. Resident #104 stated, "It burns where you are touching me." * 2:22 p.m.: After running out of wipes, the CNA (#12) used a wet wash cloth to cleanse the BM from Resident #104's peri area. The resident continued saying, "Ow, it hurts." * 2:30 p.m.: Staff rolled Resident #104 onto her right side and continued cleaning her. She stated, "It still hurts in the crease so bad." Then a nurse (#19) entered Resident #104's room. * 2:33 p.m.: Both CNAs (#12 and #21) adjusted Resident's #104 clothing. She grimaced, clenched teeth, and stated, "My ass hurts. No, I don't want to lay on my side. Why does it hurt so much? It burns like someone did something. No, its my ass that hurts." The nurse (#19) administered Resident #104's pain medication and exited the room. The pain medication was administered 56 minutes after Resident #104 first complained of having pain. * 2:38 p.m.: Both CNAs (#12 and #21) transferred Resident #104 from her bed back into her WC. Looking at the commode, Resident #104 stated, "I don't have to sit on that thing again do I?" She (#104) continued to complain of buttock pain.	F 684		

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F 684	Continued From page 21 * 2:41 p.m.: Resident #104 continued to grimace with any movement/positional change in her WC. * 2:45 p.m.: Staff transported Resident #104 to the afternoon activity. During an interview on 02/06/18 at 05:00 p.m., three administrative staff members (#3, #22 and #23) confirmed staff failed to: * recognize/acknowledge Resident #104 verbal and non-verbal signs/symptoms of pain as care-planned, * immediately address the cause(s) of Resident #104's pain as outlined on her care plan, * reposition Resident #104 on the commode, * reposition Resident #104 in the toileting sling, and * report Resident #104's continued complaints of pain throughout the 56 minute toileting care to her nurse for assessment as care-planned. These failures resulted in Resident #104 experiencing avoidable anxiety and pain while being toileted.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to ensure residents received the care and services consistent with professional	F 698	The care plans for Residents #130 and #154 were modified to reflect daily inspection of the site of the dialysis catheter on 2/7/18. The order for Renvela for Resident #130 was updated to reflect	3/18/18

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F 698	Continued From page 22 standards of practice for 2 of 2 sampled residents (#130 and #154) receiving hemodialysis. Failure to assess hemodialysis vascular access sites (arterial-venous fistula and central venous catheter) can result in complications with access function and possible loss of the access site; failure to give phosphorus-binding medications in a timely manner as ordered may result in high levels of phosphorus in the blood. Findings include: Review of the facility policy titled "Renal Dialysis Care Plan" occurred on 02/08/18. This policy, dated April 2007, stated, "I. Purpose - To ensure collaboration between the staff of Renal Dialysis ands the interdisciplinary team at VMH (Valley Memorial Homes) and the resident in the establishment and ongoing process of the Resident Care Plan. II. Procedure - A. The Care Plan Coordinator will oversee the Care Planning process to ensure that all established VMS policies and procedures regarding the Care Plan process are followed with all residents receiving Renal Dialysis. . . . D. The Renal Dialysis nurse will provide staff at VMH with their Dialysis plan of care for the resident, including goals. These will be integrated into the VMH plan of care, and will be included in the resident's medical record at VMH. " Review of the "Nursing 2017 Drug Handbook", page 1311, stated, "Renvela . . . Indications . . . To control phosphorus level in chronic kidney disease patients on dialysis. . . . Administration . . . Give drug with meals. . . . Action: Inhibits intestinal phosphate absorption and decreases phosphorus levels. . . . Patient Teaching - Instruct	F 698	that the medication needed to be given with meals on 2/14/18. All residents who are receiving hemodialysis and/or receiving Renvela in the facility have the potential to be affected by this practice. The RN Care Coordinators reviewed the care plans and medications for the issues of the inspection of the dialysis catheter for any pertinent residents on 2/8/18. The Director of Nursing Services audited any residents who receive Renvela and clarifications were made in the medication administration time by 3/8/18. Licensed Nurses will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will provide additional education on monitoring the dialysis site for signs of infection along with instructions for the medication administration for Renvela. The Staff Development RN or designee will audit the timeliness of any residents receiving Renvela on a weekly basis starting on 3/12/18 for the prior week. Upon completion of four weeks, the timeliness of administering Renvela will be audited on a monthly basis for all residents receiving the medication for the next 11 months. The RN Care Coordinator will audit all residents with dialysis on a weekly basis for the next four weeks beginning 3/12/18 to ensure care plan accuracy. Upon completion of four weeks, each resident with dialysis	

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F 698	Continued From page 23 patient to take with meals . . ." Review of the "Core Curriculum for the Dialysis Technician - A Comprehensive Review of Hemodialysis" Fifth Edition, page 46 stated, "Phosphate binders are medications used to reduce the amount of phosphorus absorbed from food. Binders bond with phosphorus from food and get rid of it in the stool. They must be taken with meals and snacks so there is phosphate in the gut. . . ." - Review of Resident #130's medical record occurred on all days of survey. Medical diagnoses for included acute kidney failure. The resident recieves hemodialysis two times per week. Physician's orders included "Renvela - Give 800 mg (milligrams) by mouth with meals related to acute kidney failure . . ." Observation of Resident #130 eating eggs, toast, and cereal for breakfast occurred on 02/06/18 at 8:05 a.m. At 9:00 a.m., observation showed a nurse (#14) administered Resident #130's Renvela medication, 55 minutes after resident had eaten breakfast. The nurse (#14) failed to administer the phosphorus-binding medication with the meal. Review of the "Core Curriculum for the Dialysis Technician - A Comprehensive Review of Hemodialysis" Fifth Edition, page 121, stated, "Vascular access makes chronic hemodialysis (HD) possible. It is a way for the care team to "access" the patient's blood for dialysis. . . . An access is an HD patient's lifeline. . . . Access problems can cause hospital stays, surgery, illness, limb loss, and death. . . ."	F 698	will have their care plan reviewed monthly and as needed for the next 12 months. The Staff Development RN will report the results of the audits to the VEC Quality Review Team for the next twelve months.	

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F 698	Continued From page 24 During an interview on 02/05/18 at 4:40 p.m., Resident #130 stated he has a catheter for dialysis (a tube placed into a central vein in the chest that leads into the heart), and not a fistula or graft (an artery and a vein connected together under the skin to provide access to the blood) in his arm for dialysis. Observation showed a central venous catheter with a dressing on Resident #130's upper right chest. Review of Resident #130's care plan occurred on 02/06/18. This care plan, revised on 10/16/17, stated, "Focus: . . . new dialysis start 6/22/17 . . . Focus: I need dialysis hemo [hemodialysis] r/t [related to] renal failure. . . . Interventions: Assist me to relieve discomfort for side effects of the disease and treatment. (Cramping, fatigue, headaches, itching, anemia, bone demineralization, . . .) Do not draw blood or take B/P [blood pressure] in arm with graft. Observe for dry skin and apply lotion as needed. Observe/document/report PRN [as needed] any s/sx [signs and symptoms] of the following: bleeding, hemorrhage, bacteremia, septic shock." During an interview on the afternoon on 02/07/18, a supervisory nurse (#17) confirmed the care plan did not identify Resident #130's central venous catheter as his hemodialysis access site and did not identify risks, complications, or care of the catheter. The nurse (#17) stated the nurses would probably assess the catheter during the weekly skin assessments, but confirmed the medical record did not show specific evidence of central venous catheter assessments.	F 698		

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F 698	Continued From page 25 The facility policy titled "Renal Dialysis/Care of Internal Access Teaching Sheet," revised August 2013, stated, ". . . Procedure . . . Check access at least every 8 hours (morning, noon, and night) to see that the blood is still flowing through it. This is done as follows: 1. Feel the access. It should not be cold. When you apply mild pressure with fingertips, you should feel a pulse. At the anastomosis [cross-connection] of the access, you should feel a "thrill" - like a buzzing inside. 2. If unable to feel access, listen through a stethoscope to the access. You should hear the blood rushing through the access (bruit). . . ." Review of Resident #154's medical record occurred on all days of survey. Diagnoses included end stage renal disease. Current physician's orders included hemodialysis three days a week. Observation showed Resident #154 had a fistula to his right arm. The record lacked evidence of monitoring the fistula site since his admission in October 2017. During an interview on 02/08/18 at 10:28 a.m., a supervisory nurse (#17) identified she received a physician's order to check the fistula site on the afternoon of 02/07/18, but the original order was to check once a day. The nurse stated she asked the physician to change the order to three times per day and updated the resident's record. The nurse identified staff should check the site three times a day, once per shift.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		3/18/18

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F 725	Continued From page 26 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and group interviews, the facility failed to assure sufficient nursing staff and related services available to meet the residents' needs for 2 of 37 sampled residents (Residents #70, #154) and 9 residents from the group interview (Resident A, B, C, E, F, H, I, J, and K) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights and physical, mental, and psychosocial well-being.	F 725	Resident #70 and Resident #154 were interviewed by staff by 3/9/18 about whether the facility is meeting their needs in a timely manner. The specific concerns of confidential Residents A, B, C, E, F, H, I, J, K are unable to be identified as the residents identities were not released by the Department of Health upon request from the facility. In order to ensure that all the residents	

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F 725	Continued From page 27 Findings include: During an interview on 02/06/18 at 10:31 a.m., Resident #70 stated "they are short of staff a lot," and he sometimes waits longer than 30 minutes for staff to answer call lights. During an interview on 02/06/18 at 5:40 p.m., Resident #154 stated he waits an hour, sometimes more for help. The resident identified he needs assistance with dressing and transferring, and call light response times are worse in the morning. Resident #154 stated, "There aren't enough [staff] to go around." The resident also identified he often has to wait for meals and, "They don't come quickly." Resident #154 stated everyone at his table doesn't always eat at the same time, even if they get there at the same time and, "They [the staff] bring them [meal trays] out one at a time." During the group interview on 02/07/18 at 2:07 p.m., when asked if staff provide cares in a timely manner, residents (identified by the facility as interviewable) responded as follows: * When asked about response to call lights, Residents A, B, C, E, F, H, I, J, and K stated they wait to long for the call lights to be answered. * Resident F identified three different occasions where she waited over an hour for the call light to be answered. * Resident F and K stated they have waited on the toilet or bed pan for up to an hour or longer for staff to help them. * Resident A, B, E, F, H, and K identified staff shut off the call light, say they will be back, and then don't come back.	F 725	identified in the survey were interviewed, all 11 of the residents who attended the group interview were interviewed by facility staff related to meeting their needs in a timely manner by 3/9/18. All residents have the potential to be affected. Staffing for Valley Eldercare Center has reflected a 5 star rating since 2015, the highest rating given by the Centers for Medicare and Medicaid Services based on numbers of nursing staff adjusted for the needs of the residents. In protecting and promoting sufficient staffing, extensive systems exist to provide it for the residents. The Facility Assessment for Valley Eldercare Center reflects the processes related to staffing which includes the process for using call light response times to contribute to staffing decisions. The Facility Assessment was provided to the survey team and is available to anyone upon request of the facility. Every Resident Council meeting addresses staff response to resident needs and will continue to do so on a monthly basis. If there is a concern, a Concern and Feedback form is initiated which triggers a follow-up investigation to resolve the issue with the resident. There were no concerns expressed by residents about call light response during the Resident Council meetings on 2/9/18 and 3/9/18.	

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F 725	Continued From page 28 * Resident A, E, and F identified they are told "We are working on it." or "We'll get back to you." and "Nothing happens."	F 725	A process change to better address resident concerns is to proactively interview residents about the responsiveness of staff to resident needs. Social services will be responsible to complete monthly interviews starting on 3/9/18 with interviewable residents for three months and quarterly thereafter for nine months regarding the staff response to their needs. A second process change is that residents with confirmed concerns related to meeting resident needs in a timely manner from the Concern and Feedback process will have follow up for the period of a month to ensure satisfaction with staff responsiveness. The plan and frequency of the follow up within that month will be dependent on the agreement between the staff and the resident with the concern. This plan was presented to Resident Council on 3/9/18 and there were positive responses to the plan. The Director of Social Services is responsible to report the summary of any Concern and Feedback investigations on a monthly basis to the VEC Quality Review Team. The Assistant Director of Nursing is responsible to report the results of staffing and call light response times on a monthly basis to the Quality Review Team on a monthly basis.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services	F 726		3/18/18

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F 726	Continued From page 29 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nursing staff were knowledgeable on the location and proper use of the suction machine on 1 of 2 units (Reeves) observed. Failure to ensure the suction machines were functional in case of an emergency situation and staff were knowledgeable regarding the	F 726	Nurses #6, #7, and #8 were given additional education on 2/7/18 regarding the proper operation of the suction machine. All residents who require emergency suctioning have the potential to be	

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F 726	Continued From page 30 location and operation of the suction machines placed residents at risk for choking and aspiration. Findings include: Observation on 02/07/18 at 11:20 a.m. showed two nurses (#6 and #7) failed to properly set-up and operate the suction machine located on the Reeves unit. Observation on 02/07/18 at 11:40 a.m. showed a nurse (#8) failed to know the location of and properly set-up and operate the suction machine located on the Reeves unit. During an interview on 02/07/18 at 1:25 p.m., a supervisory nurse (#9) verified the facility nurses failed to properly set-up the suction machine located on the Reeves unit to create a suction.	F 726	affected by this practice. Licensed Nurses will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will include a skills validation for emergency suctioning as well as information on the location of the suction machines. During monthly Code Blue Drills, the use of the suction machine will be demonstrated and education will be provided. Licensed Nurses will complete the skills validation on emergency suctioning during orientation and annually. The Staff Development RN or designee will audit the competency surrounding the use and location of suction machines with 10 nurses each week for 4 weeks beginning 3/12/18 and 10 nurses monthly for the next 11 months. The Staff Development RN will report the results of the audits to the VEC Quality Review Team for the next twelve months.	
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	F 761		3/18/18

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F 761	Continued From page 31 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: MEDICATION STORAGE 1. Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner in 1 of 5 medication carts (Lanark). Failure to store all medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Drug Administration: Nursing Department Procedure" occurred 02/08/18. This policy, dated March 2013, stated, ". . . Schedule II medications must be stored in a special narcotic cabinet/container and must be double locked. All other controlled drugs may be stored with the non-controlled medications and secured by single locking." Observation of the Lanark unit medication cart occurred on 02/07/18 at 10:45 a.m., with a nurse	F 761	All medications that were found to be expired during the survey process were discarded of as of 2/7/18. Nurse #4 was provided additional education on the standards of medication administration by 3/16/18. All residents have the potential to be affected by this practice. Licensed Nurses will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will include the standards for medication administration and the process to detect and dispose of expired medications. The Director of Nursing Services has directed nurses to audit all medication carts and medication storage rooms daily starting 2/14/18 until compliance is met. Once compliance has been determined,	

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F 761	Continued From page 32 (#4) and showed two unlabeled medication cups in the top drawer. The nurse (#4) stated the medications were prepared earlier (crushed and mixed with applesauce) for Resident #8 and included Methadone, a schedule II controlled medication. The nurse (#4) stated Resident #8 refused to take the medications, and the nurse placed the two unlabeled medication cups back in the medication cart. During an interview on 02/08/18 at 8:30 a.m., an administrative nurse (#3) stated the nurse (#4), failed to follow acceptable practices for administering and storing medications, and the nurse (#8) should have wasted the refused medications and not place them back in the cart. EXPIRED MEDICATIONS 2. Based on observation, review of facility policy, and staff interview, the facility failed to properly store medications in 3 of 8 medication storage areas (Valley Transitions medication cart, Reeves medication room, and Riverside medication room). Failure to discard expired medications increases the risk of residents receiving outdated medications with reduced efficacy. Findings include: Review of the facility policy titled "Storage of Drugs/Expiration Dating" occurred 02/08/18. This policy, dated May 2016, stated, ". . . Medications shall not be kept on hand beyond their indicated date of expiration. When the expiration date is reached medications shall be removed and destroyed according to facility policy. When dispensed in the original manufacturer packaging	F 761	the areas will be audited weekly. The Director of Nursing Services will report the results of the audits to the VEC Quality Review Team for the next twelve months.	

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F 761	Continued From page 33 the expiration date on the manufacturer's packaging label supersedes the pharmacy expiration date." Observation of the Valley Transitions back hall medication cart occurred on 02/07/18 at 10:22 a.m. and identified one bottle of I-Vite [vitamins], expired January 2018. Observation of the Reeves unit medication room occurred on 02/07/18 at 11:10 a.m. and identified one bottle of Vitamin E, expired January 2018. Observation of the Riverside unit medication room occurred on 02/07/18 at 11:30 a.m. and identified two bottles of Vitamin E, expired December 2017, and one box of acid reducer medication, expired January 2017. During an interview on 02/08/18 at 8:30 a.m., an administrative nurse (#3), agreed facility staff should have destroyed the expired medications.	F 761		
F 880 SS=D	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:	F 880		3/18/18

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F 880	Continued From page 34 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	02/08/2018

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F 880	Continued From page 35 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/16/16 Based on observation, facility policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 2 of 8 sampled residents (Resident #104 and #142) observed during personal cares. Failure to follow infection control practices related to hand hygiene and glove use has the potential to spread infection within the facility. Findings include: Review of the facility policy titled, "Handwashing/Hand Hygiene" occurred on 02/08/18. This policy, revised July 2017, stated, ". . . This facility considers hand hygiene the primary means to prevent the spread of infections . . . Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations . . .	F 880	CNAs #12 and #13 and Nurse #11 will receive additional education on hand hygiene with glove use by 3/16/18. All residents have the potential to be affected by this practice. Licensed Nurses and CNAs will attend an inservice with a post-test on 3/13/18 to 3/16/18 which will include education on hand hygiene and glove use and a hand hygiene skills validation. Starting 2/9/18, 25 random hand hygiene audits will be completed daily for seven (7) days with education being provided immediately by the CNA mentors. Upon completion of the 7 days, audits will be as follows, 50 random audits weekly times four weeks followed by 50 random audits monthly for the next 12 months. The audits will include evaluating hand	

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F 880	Continued From page 36 before and after direct contact with residents, before moving from contaminated body site to a clean body site during resident care, after removing gloves . . . perform hand hygiene before applying non-sterile gloves. . . ." - Observation on 02/06/18 at 10:00 a.m., showed a staff nurse (#11) entered Resident #142's room to perform a dressing change to the resident's tube feeding insertion site. The nurse removed the soiled dressing from the site and removed her gloves. The nurse failed to perform hand hygiene after removing her gloves and prior to applying new gloves to complete the dressing change. Observation on 02/06/18 at 10:30 a.m., showed two certified nursing assistants (CNAs) (#12 and #13) entered Resident #142's room to perform a check and change. The CNAs (#12 and #13) did not perform hand hygiene before applying gloves or in between glove changes while performing peri cares for the resident. - Observation on 02/06/18 at 1:22 p.m., showed a CNA (#12) enter Resident #104's room to assist her with using the commode. The CNA (#12) donned (applied) gloves without performing hand hygiene and began to remove resident's soiled brief. Observation on 02/06/18 at 2:24 p.m. showed a CNA (#12) performed peri cares on Resident #104. The CNA removed her soiled gloves and did not perform hand hygiene before applying new gloves and continued to perform peri cares on Resident #104.	F 880	hygiene between glove changes. The Staff Development RN will report the results of the audits to the VEC Quality Review Team for the next twelve months.	

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F 880	Continued From page 37 During an interview on 02/08/18 at 7:58 a.m., two supervisory nurses (#9 and #10) confirmed they expected staff to perform hand hygiene upon entering a resident's room and in between glove changes.	F 880		