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 _____	C 10/02/2013

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey started on September 30, 2013 and completed on October 2, 2013 the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000	All residents have the potential to be affected by this practice 11/18/13 Telephone - DON/dl	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	Valley Eldercare Center will provide education to the nurses about what constitutes a change in resident condition, notification of families of this change, and the information that needs to be charted in the resident's notes. This documentation will include the nature of the change in condition, action taken, and the notification of family/guardian. All licensed staff members will be attending one of several mandatory four hour education sessions that are being offered November 11, 12, 13, & 14, 2013. Licensed Staff that have been hired within the past two years, or who have transitioned from LPN to RN in that timeframe will be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Wilbrigue RN | TITLE: DONS | (X6) DATE: 11/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, job description, staff interview, and information provided by the complainant, the facility failed to notify the resident's legal representative/family for 2 of 27 sampled residents (Resident #1 and #27) and 1 closed record (Resident #29) with a change in condition. Failure to notify the resident's legal representative/family with a resident's change in skin condition or medication changes is an infringement of the resident's rights. Findings include: Review of the facility procedure titled "Acute Change in Condition" occurred on 10/02/13. This procedure, revised November 2005, stated, "Purpose: Response to acute change of a resident's condition in physical, cognitive, behavioral, or functional domains is essential to assure optimal quality of resident care. . . . III. The Charge Nurse response to reports or observations of changes in condition: . . . C. Communicate information to resident, appropriate family member, or other responsible party with information regarding resident's Acute Change of Condition and treatment plan. . . ." Review of the facility job description titled "LPN Charge Nurse" occurred on 10/02/13. This job	F 157	Continued from Page 1 Attending an extended version of this inservice, which is an eight hour session on November 21, 2013, instead of the four hour session. Six newer licensed staff members attended this eight hour session on October 18, 2013. This information will be discussed with the nurses at the Licensed Staff Monthly meetings on November 6 and 8, 2013. Resident #1 is no longer in the facility. Resident #27 continues to reside in the facility. The licensed staff has been inserviced on the notification of families with all med changes. Family notified of med changes 10/31/13 Resident #29 is no longer in the Telephone 11/18/13 facility. & DON 11/20 Audits will be conducted randomly on ten resident charts per unit, per month times six months, annually after that, if no problems noted. This audit will assure that changes in a	

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F 157	Continued From page 2 description, revised July 2006, stated, ". . . Functions of the Job. A. Essential . . . 1. Report changes in the resident's condition to physician, Care Coordinator, and family on a timely basis. . . ." - Review of Resident #1's medical record occurred on October 1-2, 2013 and identified the following: * 02/26/13 - Wound and Skin Progress Report: New stage 2 pressure ulcer to right buttock measuring 1 centimeter (cm) x (by) 1 cm. * 03/01/13 - Nursing Progress Note: Skin tear to right hand, measuring 3.2 cm. *09/27/13 - Wound and Skin Progress Report: Re-opened stage 2 pressure ulcer to right buttock, measuring 1.3 cm x 1.1 cm. Resident #1's record lacked evidence staff reported these changes in skin condition to the resident's legal representative/family. During an interview on 10/01/13 at 4:05 p.m., a charge nurse (#4) stated nursing staff "is supposed to call family if [residents] have a new skin tear or pressure ulcer." This nurse reviewed and verified Resident #1's record lacked documentation of family notification of the above skin conditions. - Review of Resident #27's medical record occurred on October 2, 2013 and identified a physician's order, dated 09/24/13, stating, "1) DC [discontinue] Norvasc [blood pressure medication] and MVI [multivitamin]. 2) [Decrease] KCL [potassium chloride] to 20 meq [milliequivalent] BID [twice daily]." Resident #27's record lacked evidence staff reported these medication changes to the resident's legal representative/family.	F 157	Continued from Page 2 Resident's condition are documented, along with action taken and that the family was notified (see attached). The results of these audits will be reported at the QA meetings.	11/16 2013

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F 157	Continued From page 3 During an interview on 10/02/13 at 1:50 p.m., a charge nurse (#8) stated staff notify family of new orders, like antibiotics, and she usually calls with all changes in medications. This nurse reviewed Resident #27's record and verified the record lacked documentation of family notification of the above medication changes. - Review of Resident #29's medical record occurred on 10/02/13. Diagnoses included neurotic disorders and anxiety. Resident #29's nurse's notes identified the following: * 08/01/13 "Order rec'd [received] to DC [discontinue] scheduled Ativan per pharmacy req. [request] see order." Resident #29's medical record lacked evidence staff reported this medication change to the resident's legal representative/family. During interviews on the afternoon of 10/02/13 two administrative nursing staff members (#9) and (#7) agreed staff need to notify a family member when a medication is discontinued.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225	F225 All residents with injury of unknown origin have the potential to be affected. Telephone-DON/dl 11/18/13 Valley Eldercare Center will provide education to the nurses about the action to be taken when the resident has an injury of unknown origin per VMH Policy #1.3.1: Injury of Unknown Origin (attached.) The licensed staff members will also leave a message for the appropriate Care Coordinator and notify them of the injury. The Care Coordinator will	11/16 2013

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F 225	Continued From page 4 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement established policies and procedures that prohibit mistreatment, neglect, and abuse of residents for 1 of 1 sampled resident (Resident #11) with injuries of unknown origin. Failure to investigate injuries of unknown origin placed Resident #11 and other residents at risk for mistreatment and/or abuse. Findings include:	F 225	Continued from Page 4 Investigate the injury and will document the findings of the investigation in the resident's chart. All licensed staff members will be attending one of several mandatory four hour education sessions that are being offered November 11,12,13, & 14, 2013. Licensed Staff that have been hired within the past two years, or who have transitioned from LPN to RN in that timeframe will be attending an extended version of this inservice, which is an eight hour session, instead of the four hour session. Six newer licensed staff members attended this eight hour session on October 18, 2013. This information will be also discussed with the nurses and Care Coordinators at the Licensed Staff monthly meetings on November 6 and 8, 2013. Resident #11 continues to reside at Valley Eldercare Center. The licensed staff is in the process of Investigation completed into injuries of unknown origin.	

Telephone 11/18/13 - DON/dl.

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F 225	Continued From page 5 Review of the facility policy titled, "Investigation of Alleged Resident/Tenant Abuse, Neglect or Misappropriation of Property occurred on 10/02/13. This policy, dated 09/01/13, stated, " . . . Valley Memorial Homes (VMH) shall investigate and document all alleged violations related to mistreatment, neglect or abuse, including injuries of unknown source . . . 1. Any employee witnessing or receiving reports of any alleged acts of resident/tenant abuse, neglect or misappropriation of property, injury of unknown source, crime or serious bodily injury shall report it immediately to their supervisor . . . Review of Resident #11's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current Minimum Data Set (MDS), dated 09/21/13, identified Resident #11 required total assistance from two or more people for bed mobility and transfers. Review of Resident #11's nurse's notes stated the following: 05/14/13 skin tear "Resident's daughter noticed resident had a skin tear, origin unknown. Skin tear is to right wrist measuring 1.8 cm [centimeters] [by] 0.1cm . . ." 05/15/13 skin " . . . Bruise to [right] forarm [sic]. 07/10/13 skin "Bruises on [left] hand, [left] Forearm and [Right] hand. . . ." The nurses notes failed to identify possible causes for Resident #11's skin tear and bruises. During an interview on the morning of 10/02/13, an administrative nursing staff member (#6) failed to show the facility investigated Resident #11's skin tear and bruises. This nurse stated she	F 225	Continued from Page 5 Re-education on the action taken when an injury of unknown origin occurs. The DONS or designee will conduct a minimum of ten audits per month times six months, then annually if no problems noted, of injuries of unknown origin to assure that investigations have been conducted (see attached). Results of these audits will be reported at the QA meetings.	11/~~16~~18/2013 Telephonic DON ldl 11/18/13

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F 225	Continued From page 6 expected staff to report the skin tear and bruises and she would conduct an investigation to determine the cause.	F ~~225~~ 241	All residents dependent on staff or using bedside commodes have the potential to be affected. Telephone - 11/18/13 - DON/QI	11/16 2013
F 241 SS=D	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 and staff interview, the facility staff failed to provide care for residents in a manner and environment that maintained or enhanced each resident's dignity and with respect for each resident's individuality regarding nasal secretions and facial food residue (Resident #9) and bedside commodes and bedpan visible to anyone passing by the rooms (Resident #17 and #31), on 3 of 3 days of observation (September 30, October 01-02, 2013). Failure to clean Resident #9's nasal and facial areas and failure to drape or store the commodes and bedpan for Resident #17 and #31 did not maintain or enhance the residents' dignity or recognize their individuality. Findings include: - Observation on 10/01/13 at 7:58 a.m. showed Resident #9 in bed. Two certified nursing assistants (CNAs) (#12 and #13) assisted the resident with morning cares. One CNA (#13) stated, "You still got a Kool-Aid mustache." Observation showed a red drink residue around	F 241	The Valley Eldercare Center nursing staff will be educated on dignity and privacy for residents. Resident cleanliness and the proper storage of bedpans and commodes will be addressed. CNA staff will be attending one of the mandatory inservices offered on November 6,7,8,or 9, 2013 (see attached lecture). All licensed staff members will be attending one of several mandatory four hour education sessions that are being offered November 11,12,13, & 14, 2013. Licensed Staff that have been hired within the past two years, or who have transitioned from LPN to RN in that timeframe, will be attending an extended version of this inservice which is an eight hour session, instead of the four hour session.	

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F 241	Continued From page 7 the resident's mouth. The CNA assisted Resident #9 to wash his face. Observation on 10/01/13 at 9:46 a.m. showed two CNAs (#12 and #14) assisted Resident #9 to lie down in bed. The resident had nasal secretions draining from his left nostril which ran down his face and on to his top lip. The CNAs assisted Resident #9 to bed but failed to wipe/wash the resident's face. - During the initial facility tour, on 09/30/13 at 2:30 p.m., observation of Resident #17's semi-private room identified a bedside commode with a fracture bedpan on top positioned near the resident's bed. The commode and bedpan were in full view of any visitors, residents, or staff passing by the room. Random observation throughout the day on 10/01/13 and on 10/02/13 at 7:50 a.m. showed the commode and bedpan located near Resident #17's bed, the room door open, and in full view from the hall. - Random observation throughout the day on 10/01/13 showed a bedside commode positioned near Resident #31's bed in her semi-private room. The commode was in full view of any visitors, residents, or staff passing by the room. During interview, on 10/02/13 at 8:00 a.m., a nursing management staff member (#3) reported Resident #31 used the bedside commode at night and facility staff should have stored the commode in the bathroom during the day. This staff member reported Resident #17 used the bedside commode and bedpan due to infection control precautions and facility staff should have draped	F 241	Continued from Page 7 This information will be also discussed with the nurses and Care Coordinators at the Licensed Staff monthly meetings on November 6 and 8, 2013. Resident #9 still resides at Valley Eldercare Center. Resident is being monitored for facial cleanliness. Resident #17 still resides at Valley Eldercare Center. The residents' commode and bedpan are stored out of view during the day. Resident #31 still resides at Valley Eldercare Center. Residents' bedside commode is stored out of view during the day. The Staff Development/Infection Control Nurse and the Licensed Staff will conduct Dignity Audits on a minimum of 20 residents per unit, per month times six months, then annually if no problems noted (see attached).	

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F 241	Continued From page 8 these items or stored them in the bathroom when not in use.	F 241	Continued from Page 8 These audits will assure that the resident's face, hands, and clothing are clean. Privacy Audits will be done on twenty rooms per unit, per month times six months, then annually if no problems noted. This audit will be done at varying times, to assure that items such as commodes and bed pans are stored out of sight during the day/pm shift (see attached). The results of these audits will be reported to the QA meetings.	11/16 2013
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, review of facility policy and procedure, record review, and staff interview, the facility failed to review and revise the care plans for 3 of 27 sampled residents (Resident #1, #4 and #17). Failure to include information and staff approaches regarding incontinence, ambulation, and use of hi-low bed (Resident #1), urinary retention, necessity for catheterization, and	F280	All residents have the potential to be affected. 11/18/13 Telephone - DON/dl	11/16 2013
		F 280	Valley Eldercare Center licensed staff will be educated on the procedure for updating resident careplans as changes occur and the importance of putting all changes to the resident's care plan on the careplan. All licensed staff members will be attending one of several mandatory four hour education sessions that are being offered November 11, 12,13, &	

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F 280	Continued From page 9 approaches regarding catheter care (Resident #4), and Clostridium difficile (C. diff) (Resident #17) limited the staff's ability to communicate the care needs and ensure continuity of care for the residents. Findings include: The Centers for Disease Control and Prevention website, cdc.gov, reviewed on 10/02/13, stated ". . . Clostridium difficile . . . is a germ that can cause diarrhea. . . . People who have other illnesses or conditions requiring prolonged use of antibiotics, and the elderly, are at greater risk of acquiring this disease. The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to patients or contaminate surfaces through hand contact. . . ." Review of the facility policy/procedure titled, "Care Plan Process, Role of Charge Nurse in" occurred on 10/02/13. This policy, dated October of 2010, stated the following: "Purpose: To ensure that the Resident Care Plan is implemented, reviewed and revised as necessary by the licensed Nurse caring for the resident. . . . Policy: The Resident Care Plan will reflect the needs and Plan of Care for the resident, and will be updated on an on-going basis as the resident has a need for a change in plan of care. The RN [registered nurse] Care Coordinator will oversee the process and will have ultimate responsibility, with collaboration of the Charge Nurse and Care Plan Team." - During the initial facility tour, on 09/30/13 at 2:30	F 280	Continued from Page 9 14, 2013. Licensed Staff that have been hired within the past two years, or who have transitioned from LPN to RN in that timeframe will be attending an extended version of this inservice, which is an eight hour session, instead of the four hour session. This information will be also discussed with the nurses and Care Coordinators at the Licensed Staff monthly meetings on November 6 and 8, 2013. Resident #1 is no longer in the facility. Resident #4 continues to reside at Valley Eldercare Center. The resident's careplan has been updated to include indwelling catheter. Resident #17 still resides at Valley Eldercare and is no longer on isolation precautions. The Careplan Coordinators will complete Careplan Audits on 5	

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F 280	Continued From page 10 p.m., observation in the hall outside Resident #17's semi-private room identified a cart with a card labeled "Contact Precautions" and sign at the doorway instructing individuals to see the nurse before entering the room. A supervisory nursing staff member (#1) reported the precautions and instructions were due to Resident #17 having "C. diff." Review of Resident #17's medical record occurred on October 1-2, 2013. The resident's medical record identified positive laboratory results for C. diff on 09/09/13 and contact precautions initiated on that date. Resident #17's admission Minimum Data Set (MDS), dated 08/25/13, identified the resident was cognitively intact and always incontinent of bowel movements. Resident #17's current care plan, dated 09/09/13, stated "Problems . . . C-Diff . . ." The care plan failed to include interventions or approaches for staff regarding precautions related to C. diff, such as use of the toilet or commode, resident hand washing, and resident to resident contact. The care plan failed to include approaches regarding resident education for handwashing, contact with other residents, or toileting when Resident #17 left the room. The resident's care plan identified she is occasionally incontinent of bowel. Resident #17's Resident Care Notes stated the following: *09/20/13, 5:30 p.m. - ". . . Has had formed stools x [times] 2 days. . . . Up in parlor & [and] common area most of afternoon. Action: Continue [with] Flagyl [an amebicide] et [and] contact precautions." *09/30/13, 3:00 p.m. - ". . . Res. [Resident] has	F 280	Continued from Page 10 Careplans per unit, per month times six months, then annually if no problems noted, to assure that the careplan is being updated by the nursing staff (see attached). The results of these audits will be reported to the QA meetings.	11/16 2013

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	355067	A. BUILDING _____ B. WING _____	C 10/02/2013

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F 280	Continued From page 11	F 280		

completed course of Flagyl. Plan: Will have nurse assess stool [with] next BM [bowel movement]." *10/01/13, 3:30 p.m. - ". . . Had formed stool today. Will remove off of isolation."

Observation in the afternoon on 10/01/13 showed Resident #17 out of her room. During interview, on 10/01/13 at 3:25 p.m., a supervisory nursing staff member (#2) reported Resident #17 was "shopping with activities." Observation showed the resident returned to the resident care unit at 3:30 p.m. and had been shopping, prior to discontinuation of contact precautions for C. diff.

During interview, on 10/02/13 at 7:50 a.m., a nursing management staff member (#3) confirmed Resident #17's care plan failed to include approaches, interventions, and resident education regarding C. diff.

Failure to review and revise Resident #17's current care plan to include approaches, interventions, and resident education regarding precautions related to C. diff limited the staff's ability to ensure the continuity of care, the potential for resident to resident contact, and resident to community contact.

- Review of Resident #4's medical record occurred on October 1-2, 2013. Resident #4's diagnoses included hemiplegia and benign prostatic hypertrophy (BPH). The admission MDS, dated 09/10/13, identified an indwelling foley catheter and intermittent catheterization.

Resident #4's Resident Care Notes identified the following:
* 09/03/13 ". . . Reports incontinence [with] bowel et [and] bladder. Uses the urinal for voiding."

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F 280	Continued From page 12 * 09/04/13 3:29 a.m. ". . . unable to void this shift . . . cathed for 850 ml [milliliters]." * 09/05/13 3:31 a.m. ". . . no void this shift . . . cathed for 600 ml." * 09/05/13 6:50 p.m. "received order to insert foley tonight and remove 09/09/13." * 09/09/13 6:10 a.m. "foley removed." * 09/11/13 3:00 a.m. "unable to void . . . cathed for 250 ml." * 09/22/13 ". . . foley catheter - draining." * 09/29/13 ". . . catheter patent draining clear yellow urine." A physician order, on 09/12/13, stated "Reinsert foley d/t [due to] high residual." Observation on 10/01/13 at 5:50 p.m. showed Resident #4 utilizing a leg drainage bag for urinary collection. Resident #4's current comprehensive care plan, dated 09/03/13, stated the following: "Problems - I have a self care deficit manifested by need for assist with ADLs [Activities of Daily Living] . . . Interventions . . . Toileting: I require assist of 2 [with] Pal [stand up mechanical lift] lift with toileting. I am incontinent of bowel and bladder. I use a urinal at bedside at night. . . ." The care plan failed to include Resident #4's problem of urinary retention, inability to void, the use of intermittent urinary catheterization, and insertion of an indwelling foley catheter. The care plan also failed to identify approaches/interventions necessary to care for Resident #4's indwelling catheter which was inserted 20 days previously. During interview, on 10/01/13 at 5:55 p.m., a nursing management staff member (#5) confirmed Resident #4's care plan failed to	F 280		

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F 280	Continued From page 13 include the approaches/interventions necessary to care for Resident #4's indwelling catheter. - Review of Resident #1's medical record occurred on October 1-2, 2013. The current care plan stated, "Problems/Strengths: I have a need for assist with my ADLs [activities of daily living] r/t [related to] weakness. . . . Interventions: Toileting: . . . I am incontinent of bladder at times and continent of bowel. . . . Problems/Strengths: I have a potential for injury, falls m/b [manifested by] need for assist r/t balance with transitions. . . . Interventions: I transfer with assist of 1-2 and FWW [front wheeled walker]. I am able to ambulate with assist of 1-2 with FWW. . . ." The quarterly MDS, dated 07/17/13, indicated Resident #1 did not walk in room/corridor and had frequent bowel incontinence. Observation on 10/01/13 at 3:30 p.m. showed Resident #1's brief contained stool prior to toileting. Observation throughout the survey showed Resident #1 did not ambulate, transferred with a stand-up mechanical lift, and utilized a hi-low bed in the low position while in bed. During an interview on 10/02/13 at 4:27 p.m., a nurse manager (#9) stated Resident #1 hasn't walked for many months. This nurse verified the current care plan lacked the intervention of a hi-low bed used in the low position, and failed to reflect the resident's current status related to bowel continence, transferring, and ambulation.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F281 All residents with medications/ PICC lines have the potential to be affected. 11/18/13 - Telephone - DON/dl The licensed staff members will be	

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F 281	Continued From page 14 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, review of professional literature, staff interview, and information provided by the complainant, the facility failed to follow professional standards of care including accurately transcribing physician's orders to the medication administration record (MAR) for 1 of 27 sampled residents (Resident #6) and clarifying a physician's order to ensure the label of medication received from pharmacy identified the correct instructions for 1 of 2 supplemental residents (Resident #32); and failed to flush a peripherally inserted central catheter (PICC) every 12 hours as ordered for 1 of 3 closed records (Resident #28). Failure to follow professional standards in transcribing physician orders to the MAR, failure to identify and clarify incomplete administration directions on medication labels/MARs, and failure to flush PICC lines as ordered, placed the residents at risk for adverse health effects and increased the risk of medication errors. Findings include: Kozier and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice" 9th edition, Pearson Education, Inc., Upper Saddle River, New Jersey, page 852, stated "The nurse should always question the primary care provider about any order that is ambiguous." Page 867, stated ". . . Performance . . . 1. . . . While preparing the medication, recheck each	F 281	Continued from Page 14 Educated on the professional standards for medication administration, clarification of physician orders, review of the VMH Medication Administration policy and the "Rights" and a review of the VMH policy for flushing of PICC lines. All licensed staff members will be attending one of several mandatory four hour education sessions that are being offered November 11,12,13 & 14, 2013. Licensed Staff that have been hired within the past two years, or who have transitioned from LPN to RN in that timeframe will be attending an extended version of this inservice, which is an eight hour session on November 21, 2013, instead of the four hour session. This information will be also discussed with the nurses and Careplan Coordinators at the Licensed Staff monthly meetings on November 6 and 8, 2013. The Health Unit Coordinators were inserviced on October 21, 2013	

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F 281	Continued From page 15 prepared drug and container with the MAR again. Rationale: This second safety check reduces the chance of error." Page 899 stated, "Intermittent Infusion Devices. Clients who require long-term venous access for administering medications . . . may have a specialized catheter . . . to allow central venous access. " Page 1484 stated, "Special precautions need to be taken with all central lines . . . to ensure . . . catheter patency." Review of the facility policy titled "Medication Administration" occurred on 10/02/13. This policy, dated February of 2011, stated, "1. Check Medication Administration Record (MAR) and read each order entirely. 2. Remove appropriate medication from the drawer and compare label to MAR when removing from drawer, when dispensing, and when replacing it in the drawer. The following information is assessed: right resident, right medication, right dose, right time, right route, right reason, right documentation, and right to refuse the medication. . . . Essential Points 4. If there are any discrepancies between the MAR and medication prescription label, consult the physician orders in the resident record. . . . Medication Administration Record and Resident Chart 1. Orders on The MAR must be entered exactly as received on the physician order form." Review of the facility policy titled "Intravascular Access Devices" occurred on 10/02/13. This policy, dated July of 2012, stated, "PICC . . . flush . . . Frequency: every 12 hours and prn [as needed]." Information received from a complainant included	F 281	Continued from Page 15 On the charting of PICC lines and portacaths. Residents #6, 32, and 28 are no longer residing at Valley Eldercare Center. MAR Audits will be conducted randomly by the DONS or designee on ten resident MARs per unit, per month times six months, then annually if no problems noted, to assure that orders are complete and that PICC policies are followed, if applicable. The results of these audits will be reported to the QA meetings.	11/16 2013

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F 281	Continued From page 16 a concern that the PICC line was not flushed two times a day as ordered by the physician. - Review of the closed record for Resident #28 occurred on 10/02/13. On admission a physician's order identified "Vancomycin (an antibiotic) 1 G [gram] every 24 hours. Flushes . . . per protocol." The MAR identified for the first 5 days after admission Resident received Vancomycin once every 24 hours and flushes of the PICC line every 12 hours. Six days after admission, the physician ordered the Vancomycin every 12 hours. Ten days after admission the physician ordered the Vancomycin every 18 hours. For the next 24 days (August 13-September 5), Resident #28's MARs identified the Vancomycin administered every 18 hours but failed to identify the PICC line flushes every 12 hours. During interview on 10/02/13 at 5:30 p.m., a nurse manager (#7) confirmed staff flushed Resident #28's PICC line every 18 hours with the antibiotic and not every 12 hours as per facility policy. - Observation on 10/01/13 at 10:30 a.m. showed a nurse (#10) administered Cipro (an antibiotic) via Resident #6's PICC. The label identified the intravenous (IV) bag of medication as Cipro 400 milligrams (mg) in 200 milliliters (ml).The MAR identified the medication as Cipro 200 ml (milliliters) IV every 24 hours. Review of Resident #6's medical record occurred October 1-2, 2013 and identified receipt of a physician order, on 08/29/13, for Cipro 400 mg in 200 ml IV every 24 hours. The MARs for August, September, and October failed to identify the	F 281		

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F 281	Continued From page 17 dosage of 400 mg of Cipro. - Observation on 10/01/13 at 7:58 a.m. showed a nurse (#10) prepared to administer Refresh 1% opthalmic solution (eye drops) to Resident #32. The label on the box of eye drops and the MAR listed directions of one drop to eye daily. When asked by the surveyor, the nurse (#10) confirmed the directions failed to identify which eye and stated she would check with the nurse practitioner. Review of Resident #32's medical record occurred on 10/01/13 and identified receipt of the original order of the Refresh one drop to eye daily on 07/16/2013, upon the resident's admission to the facility. Review of the MARs for the months of July, August, September and October identified the Refresh "one drop to eye daily." The facility failed to clarify the order received 2-1/2 months previously for Resident #32's eye drops. During an interview on 10/02/13 at 3:35 p.m., a nurse manager (#11) confirmed the MARS for Residents #32 and #6 were inaccurate.	F 281		11/16/2013