STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	C 12/20/2018

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WESTERN HORIZONS CARE CENTER	**1104 HWY 12 HETTINGER, ND 58639**

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and complaint survey started on 12/17/18 and concluded 12/20/18.	F 000		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 01/25/18 Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 2 of 14 sampled residents (Resident #27, and #30). Failure to accurately complete Section I (Active Diagnoses) and Section J (Health Conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may 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 2018, pages I-7 stated, ". . . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current	F 641	F641 Accuracy of Assessments 1. Resident #27s MDS dated 11/8/18 section I5900 was reviewed and found to be coded correctly. Resident #30s MDS sections J1300 and J1800 and the care plan were reviewed and updated for smoking status and fall status. MDS was modified and exported. 2. All residents have the potential to be affected. All resident's MDS sections I and J, along with the care plans were reviewed and updated as necessary. 3. Education will be provided to the MDS Coordinator by 1/24/19 by Sandy White, RN, QA/IC. Policy updated on 12/24/18. 4. QA nurse will audit MDS sections I and J weekly X4, monthly X2, and quarterly X3. Modifications will be completed when necessary. QA nurse will report audit findings at the monthly QAPI meetings for review.	1/24/19

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

Electronically Signed | 01/10/2019

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F 641	Continued From page 1 functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring . . . during the 7-day look-back period . . . " Review of Resident #27's medical record occurred on all days of survey. Diagnoses included bipolar disorder. Physician orders included Seroquel (antipsychotic) with treatment diagnosis listed as bipolar disorder. An annual MDS, dated 11/08/18, identified facility staff failed to code section I5900 for a diagnosis of bipolar disease. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, page J-24 stated, ". . . J1300: Current Tobacco Use: . . . Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. . . ." - Review of Resident #30's medical record occurred on all days of survey. Observation on 12/19/18 at 8:08 a.m. showed Resident #30 outside smoking. A progress note, dated 11/08/18, stated, ". . . Resident is a smoker and does go out of the facility to smoke . . ." An annual MDS, dated 11/14/18, showed staff failed to code section J1300, Yes: current tobacco use. During an interview on 12/18/18 at 4:20 p.m., an administrative nurse (#5) confirmed staff failed to code the resident's current tobacco use at J1300 for the 11/14/18 MDS. The Long-Term Care Facility RAI User's Manual,	F 641	5. Corrective actions will be completed by January 24, 2019.	

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F 641	Continued From page 2 revised October 2018, pages J-33 stated, ". . . J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment . . . whichever is more recent . . . Code 0, none: if the resident had no injuries fall since the admission/entry or reentry or prior assessment . . . Code 1, one: if the resident had one non-injuries fall since admission/entry or reentry or prior assessment . . . Code 2, two or more: if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment . . ." Review of section J 1900 on Resident #30's quarterly MDS, dated 11/14/18, identified a fall with injury during the look-back period. Review of the resident's medical record during the look back period failed to show a fall with injury, however the record indicated a fall with no injury. During an interview on the afternoon of 12/18/18, an administrative nurse (#5) confirmed staff failed to code J1800 correctly as a fall with no injury for the 11/14/18 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 assessment, care planning, and transitions of	F 644		1/24/19

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F 644	Continued From page 3 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 (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 2 sampled residents (Resident #27) who had a new mental illness diagnosis added after admission to the facility. Failure to complete a change in status assessment for Resident #27 may result in the residents not receiving the appropriate care and services for their mental health disorders. Findings include: The North Dakota PASARR Provider Manual, page 13, stated, ". . . 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, IDF, and/or RC [mental illness, intellectual disability, and/or related conditions] was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ."	F 644	F644 Coordination of PASARR and Assessments 1. Ascend will be contacted regarding Level 1 PASARR screen update for resident #27. 2. All residents with MI, IDF, and/or RC have the potential to be affected. All residents with MI, IDF, and/or RC will be reviewed to determine if Ascend needs to be notified regarding a Level 1 PASARR update. 3. Policy updated on 12/24/18. Education will be provided to the Director of Nursing by 1/24/19 by Duane Fried, RN/Discharge Planner at West River Health Services. 4. QA nurse will audit new admissions and residents with new diagnosis of MI, IDF, and/or RC weekly X4, monthly X2, and quarterly X3. QA nurse will report audit findings at the monthly QAPI meetings for review. 5. Corrective actions will be completed by January 24, 2019.	

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F 644	Continued From page 4 Review of Resident #27's medical record occurred on all days of survey. The record showed an initial Level I PASARR, completed on 11/07/17, identified no diagnosis of a major mental illness (MMI). A physician progress note, dated 11/16/17, identified a diagnosis of bipolar affective disorder. The record lacked evidence of an updated Level I PASARR rescreening/change in status assessment for the new diagnosis. During an interview on 12/19/18 at 4:29 p.m., an administrative staff member (#5) stated staff failed to complete a new Level I PASARR for Resident #27's new diagnosis of bipolar affective disorder.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		1/24/19

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F 657	Continued From page 5 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 01/25/18 Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 3 of 14 sampled residents (Resident #12, #23, and #30). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 12/20/18. This policy, revised on 01/30/18, stated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each	F 657	F657 Care Plan Timing and Revision 1. Resident #12s care plan was updated to reflect behavior management including goals and interventions to help address behaviors. Resident #23s care plan was updated to reflect current care regarding hematoma and bruising. Resident #30s care plan was updated to reflect current smoking plan. 2. All residents have the potential to be affected. All other residents with behaviors, skin injuries, or residents that smoke will be reviewed and updated as necessary. 3. Care plan policy reviewed and updated on 12/24/18. Education will be provided to the care planning team by 1/24/19, by Dawn Bunn, RN/MDS Coordinator; Judy Jung, Director of Nursing; and Sandy White, RN/QA/IC. 4. MDS nurse will audit care plans of residents with behaviors, skin injuries, or residents that smoke to ensure care plans	

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F 657	Continued From page 6 comprehensive and quarterly MDS [Minimum Data Set] assessment, and any significant changes . . ." - Review of Resident #12's medical record occurred on all days of survey. Review of Resident #12's Behavior Charting from August 18 - December 19, 2018 identified the following behaviors: * 23 documented incidents of yelling/screaming out/crying * 17 documented incidents of hitting/kicking/pulling/scratching staff * 6 documented incidents of rejection of cares * 2 documented incidents of wandering Resident #12's care plan failed to identify the above behaviors and lacked goals and interventions to address these behaviors. - Review of Resident #23's medical record occurred on all days of survey. Observations on all days of survey showed Resident #23 with bruising around both eyes and a hematoma to the right side of the forehead. A progress note, dated 11/22/18, stated, ". . . While CNA was preparing resident for transfer in standup lift, as she guided her feet to the platform, arm of standup lift accident [sic] hit resident on right forehead causing a hematoma . . ." Resident #23's care plan failed to address the hematoma (swollen tissue) to the right side of the forehead with bruising. - Review of Resident #30 medical record occurred on all days of survey. The Annual MDS, dated 11/14/18, identified the resident cognitively	F 657	are current. Audits will be performed weekly X4, monthly X2, and quarterly X3. MDS nurse will report audit findings at monthly QAPI meetings for review. 5. Corrective actions will be completed by January 24, 2019.	

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F 657	Continued From page 7 intact. Observation on 12/19/18 at 8:08 a.m. showed Resident #30 outside smoking with an unidentified staff member supervising. Resident had his own supplies and smoked independently. During an interview on 12/19/18 at approximately 8:15 a.m. Resident #30 showed and explained the use of the pendant. He stated the pendant allows him to notify staff if needed. The current care plan stated, ". . . SMOKING: [resident] prefers to smoke. He will ambulate with his walker to the designated smoking area . . . Smoking assessment will be done quarterly and with significant changes . . . [resident] is a smoker. He goes outside several times each day to smoke in the designated smoking area. Does this independently. . . . Encourage [resident] to always notify staff that he is leaving the building to smoke, so they are aware of where he is. Monitor him for staying within rules and regulations for using the outdoor smoking area, as he does not always follow them. . . ." Resident #30's care plan failed to address the resident carrying and storing his own smoking supplies including a lighter. During an interview on 12/18/18 at 4:50 p.m., an administrative nurse (#5) confirmed she would expect staff to include these areas on the care plan.	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-	F 658		1/24/19

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F 658	Continued From page 8 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, policy review and review of professional reference, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #30) with orders for continuous oxygen. Failure to provide oxygen (O2) as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1257-1259, stated, "OXYGEN THERAPY . . . Determining the effectiveness of oxygen therapy involves several measure, including checking vital signs . . . oxygen saturations . . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." Review of the procedure titled "Oxygen Administration" occurred on 12/20/18. This policy, revised January 2018, stated, ". . . Provide guidelines for safe oxygen administration . . . Verify that there is a physician's order for this procedure . . . Before administering oxygen, and while the resident is receiving oxygen therapy, assess the following: . . . signs or symptoms of	F 658	F658 Services Provided Meet Professional Standards 1. O2 sats bid was placed on the TAR along with O2 use and parameters for O2 use for resident #30. 2. All residents prescribed continuous or prn oxygen have the potential to be affected. All resident's orders were reviewed for prescribed oxygen use. Two other residents were identified. O2 sats bid were on the TAR for both residents. 3. When an order for O2 use is obtained, O2 sats and lung sound assessments will be included in the orders and placed on the TAR. Education will be provided to the nursing staff by 1/24/19 by Judy Jung, Director of Nursing. Policy was updated on 1/2/19. 4. Residents receiving continuous or prn oxygen will have records reviewed by QA nurse to determine compliance. Audits will be performed weekly X4, monthly X2, and quarterly X3. QA nurse will report audit findings at the monthly QAPI meetings for review. 5. Corrective actions will be completed by January 24, 2019.	

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F 658	Continued From page 9 cyanosis (i.e., blue tone to the skin and mucous membranes); . . . signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion) . . . vital signs, lung sounds, oxygen saturations. . . ." Review of Resident #30's medical record occurred on all days of survey. The current physician's order stated, "O2 @ 2L [liters]/NC [nasal cannula] - as needed related to chronic obstructive pulmonary disease [COPD] . . . To maintain O2 Saturations > [greater than] 90%. Notify Dr. [name] if lower than 85% . . . O2 @ 2L/NC @ HS [night] . . ." Resident #30's current care plan stated, ". . . diagnosis of COPD . . . O2 per orders . . . Report signs of exacerbation of COPD to Practitioner . . ." The medical record lacked evidence of nursing assessments of lung sounds and oxygen saturations since November 17th, 2018. During an interview on 12/20/18, an administrative nurse (#6) confirmed nursing staff should be monitoring Resident #30's oxygen saturations as ordered. The facility failed to regularly check the resident's oxygen saturations prior to applying the oxygen.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		1/24/19

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F 692	Continued From page 10 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 01/25/18 Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 2 of 6 sampled residents (Resident #6 and #32) observed during cares and required staff assistance for fluid intake. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Hydration Management" occurred on 12/20/18. This policy, dated February 2018, stated, ". . . 2. Nursing staff will offer fluids to each resident every time they enter the resident's room. . . ."	F 692	F692 Nutrition/Hydration Status Maintenance 1. Resident #6 and #32/s care plans were updated for hydration needs. Hydration added to Aide task list. 2. All other residents that are not independent with hydration have the potential to be affected. All other residents were reviewed to determine independent hydration. Care plans and task lists were updated for those residents that require assistance with hydration. 3. All new admissions and those residents with significant changes will be assessed for hydration assistance by the QA	

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F 692	Continued From page 11 - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, " . . . [Resident name] has need for adequate nutrition [related to] poor appetite and poor intake. . . . Will be offered assistance, encouragement and cueing with meals. . . ." The quarterly Minimum Data Set (MDS), dated 09/28/18, identified the resident required extensive assist for bed mobility and eating. Observation on 12/17/18 at 3:12 p.m. showed two certified nurse aides (CNAs) (#1 and #2) failed to offer fluids to Resident #6 after checking the resident's brief and repositioning the resident. Observation on 12/18/18 at 4:15 p.m. showed two CNAs (#3 and #4) failed to offer fluids to Resident #6 after transferring the resident from the bed to the wheel chair. - Review of Resident #32's medical record occurred on all days of survey. The nursing progress notes stated, 12/17/18 at 6:12 a.m. "Clarification on orders . . . Offer sips of fluid as tolerated. Comfort measures no code status, end of life care . . . " Observation on 12/17/18 at 3:34 p.m. showed two CNAs (#1 and #2) failed to offer fluids to Resident #32 after incontinence care. During an interview on 12/20/18 at 7:10 a.m., an administrative nurse (#5) confirmed she expected staff to offer fluids with cares.	F 692	nurse/designee. Education will be provided to nursing staff by 1/24/19 by Dawn Bunn, RN/MDS Coordinator; Judy Jung, Director of Nursing; and Sandy White, RN/QA/IC. 4. QA nurse will audit assistance with hydration weekly X4, monthly X2, and quarterly X3. QA nurse will report the audit findings at the monthly QAPI meetings for review. 5. Corrective actions will be completed by January 24, 2019.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		1/24/19

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F 757	Continued From page 12 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident's medication regimen was free of unnecessary medications for 4 of 4 sampled residents (Resident #27, #28, #30, and #33) reviewed. Failure to ensure the resident's medication regimen was assessed for any side effects may result in the resident receiving unnecessary medication and experiencing adverse consequences related to the medication. Findings include: Review of the facility policy titled "Psychotropic	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. AIMS testing will be performed for resident #27, #28, #30, and #33. 2. All residents receiving antipsychotic medications and Reglan have the potential to be affected. Records were reviewed for those residents receiving antipsychotic medication or Reglan. AIMS testing will be performed on those residents that were identified in the review.	

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F 757	Continued From page 13 Medication, Use Of" occurred on 12/19/18. This policy, dated 09/01/2007, stated, "The intent of this policy is to ensure adequate monitoring and efficacy of psychotropic medications. . . . AIMS (Abnormal Involuntary Movement Scale) will be completed every 6 months, following a baseline evaluation, for residents at risk for Tardive Dyskinesia [TD]." - Resident #27's electronic medication administration record (EMAR) and the care plan identified the resident received Seroquel (antipsychotic medication) since 09/15/18, with a physician order to increase the dose on 12/14/18. Resident #27's medical record lacked an AIMS assessment completed since January 2018. - Review of Resident #28's medical record occurred on all days of survey and the physician's orders stated, " . . . Abilify [an antipsychotic medication] 2 milligrams (mg) one time a day (QD)" started on 09/07/18. Resident #28's medical record lacked a baseline AIMS assessment. - Review of Resident #30's medical record occurred on all days of survey and the physician's orders stated, " . . . Abilify 5 mg QD . . ." Resident #30's medical record lacked an AIMS assessment. - Review of Resident #33's medical record occurred on all days of survey and the physician's orders stated, " . . . Abilify 1 mg QD . . ." Resident #33's had a dose reduction on 12/17/18, however the medical record lacked an AIMS assessment.	F 757	3. Any resident with a prescribed antipsychotic or Reglan order will have an AIMS test completed per policy. Policy reviewed and updated 12/21/18. Education will be provided to nursing staff by 1/24/19 by Dawn Bunn, RN/MDS Coordinator. 4. Resident records will be reviewed for those residents receiving antipsychotics or Reglan by the QA nurse to determine AIMS testing compliance. Audits will be performed weekly X4, monthly X2, and quarterly X3. The QA nurse will report audit findings at the monthly QAPI meetings for review. 5. Corrective actions will be completed by January 24, 2019.	

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F 757	Continued From page 14 During an interview on 12/19/18 at 1:12 p.m., an administrative staff member (#5) stated she failed to locate AIMS assessments for the above residents.	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 sampled resident (Resident #28) who experienced a significant medication error. Failure of staff to administer medications as ordered may have a negative impact on a resident's quality of life. Findings include: Review of the facility policy titled "Administration of Meds" occurred on 12/20/18. This policy, revised August 2017, stated, ". . . Medications must be administered in accordance with the orders . . ." Review of Resident #28's medical record occurred on all days of the survey. Diagnoses included congestive heart failure. A physician order dated 09/25/18, stated, ". . . Torsemide [a diuretic]10 milligrams [mg] by mouth every 24 hours as needed for weight gain, increased edema, crackles tin [sic] bilateral bases related to heart failure . . . wt. [weight] baseline (213) give if 5 pounds more."	F 760	F760 Residents are Free of Significant Med Errors 1. Resident #28s orders were changed on the MAR to include specific parameters regarding weight when the prn diuretic is to be given. 2. All residents receiving a prn diuretic with specific parameters regarding weight have the potential to be affected. Record review was completed for residents receiving a prn diuretic with specific parameters regarding weight. One resident was identified and compliance was noted. 3. When there is an order change regarding a prn diuretic and specific parameters regarding weight, the medication and weight will be placed on the MAR together. Medication policy was updated on 12/24/18. Education will be provided to nursing staff by 1/24/19 by Judy Jung, Director of Nursing and Sandy White, RN/QA/IC.	1/24/19

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F 760	Continued From page 15 Review of the Medication Administration Record for December 1-19, 2018, identified Resident #28 received Torsemide 10 mg on December 2, 3, 8, 17, and 19 for a weight of 5 pounds above the basline weight. Review of Resident #28's weights for December 1-19, 2018, identified the following weights of 5 pounds above the baseline weight of 213 and staff failed to administer the as needed Torsemide: 12/01/18 - 219.2 lbs [pounds] 12/04/18 - 220 lbs 12/05/18 - 220 lbs 12/06/18 - 220.5 lbs 12/09/18 - 220 lbs 12/14/18 - 220 lbs 12/15/18 - 220 lbs 12/16/18 - 221 lbs Staff failed to administer the as needed Torsemide for 8 of 13 days. During an interview on 12/20/18 at 7:10 a.m., an administrative nurse (#5) confirmed staff failed to administer the Torsemide as ordered.	F 760	4. Records of residents receiving a prn diuretic with specific parameters regarding weight will be audited by the QA nurse weekly X4, monthly X2, and quarterly X3. Audit findings will be reported at the monthly QAPI meeting by the QA nurse for review. 5. Corrective actions will be completed by January 24, 2019.	
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	F 761		1/24/19

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F 761	Continued From page 16 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store medications properly for 1 of 2 medication refrigerators (east medication room refrigerator). Failure to store medications in a safe environment may result in reduced effectiveness of medications. Findings include: Review of the facility policy titled, "Refrigerators and Freezers" occurred on 12/19/18. This policy, dated 09/01/2007, stated, ". . . Acceptable temperatures should be 35 degrees F [Fahrenheit] and 40 degrees F for refrigerators . . . Monthly tracking sheet for all refrigerators and freezers will be posted to record temperatures. Monthly tracking sheets will include time, temperature, initials, and action taken. The last column will be completed only if temperatures	F 761	F761 Label/Store Drugs and Biologicals 1. A new thermometer was placed in the east medication refrigerator. Temperature was found to be within the normal limits. 2. All other medication refrigerators have the potential to be affected. West medication refrigerator log indicated temperatures within normal limits. There are no other medication refrigerators located in the facility. 3. Nursing staff will keep a daily log of refrigerator temperatures for the east and west medication refrigerators. Nursing staff will report any temperatures above or below normal to the DON/Designee. Education will be provided by 1/24/19 by Sandy White, RN/QA/IC. Policy was	

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F 761	Continued From page 17 are not acceptable. . . . The supervisor and/or Designee will take immediate action if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet, including the repair personnel and/or department contacted. . . ." A tour of the east medication room occurred on 12/19/18 at 2:32 p.m. with a facility certified medication assistant (CMA) (#7). The medication refrigerator contained one thermometer that displayed a temperature reading of 30 degrees F, and confirmed by the CMA (#7).The refrigerator contained the following medications: * Trulicity (diabetic injectable medication) * Levemir (injectable insulin) * NovoLog (injectable insulin) * Lantus (injectable insulin) * Basaglar (injectable insulin) Medications contained in the vials/pens did not appear frozen. A review of the manufacturer instructions for all the above medications stated the medications are to be stored in the refrigerator at 36- 46 degrees F. The facility Refrigerator Temps (temperatures) tracking sheet identified temperatures were to remain between 39-46 degrees F. Review of the Refrigerator Temps tracking sheet for the east medication room refrigerator from 12/1/18-12/19/18 identified 13 incidents of temperatures out of the range identified. Facility staff failed to document any actions taken for temperatures out of range. During an interview on 12/19/18 at 2:40 p.m., the	F 761	reviewed and updated on 12/21/18. 4. QA nurse will audit east and west medication refrigerator temperatures weekly X4, monthly X2, and quarterly X3. QA nurse will audit findings at the monthly QAPI meetings for review. 5. Corrective actions will be completed by January 24, 2019.	

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F 761	Continued From page 18 CMA (#7) stated the nursing/CMA staff adjust the temperature when needed. During a review of the east medication room refrigerator on 12/19/18 at 3:01 p.m., the administrative staff member (#5), confirmed the thermostat reading at 30 degrees F, and confirmed the facility nursing/CMA staff should notify him/her when the temperature readings are above or below 39-46 degrees as stated on the monitoring sheet. Manufacturer directions regarding storage temperatures for the medications contained in the refrigerator were reviewed with the administrative staff member (#5). The administrative staff member (#5) acknowledged the temperatures on the refrigerator temperature tracking sheet failed to reflect the manufacturers guidelines.	F 761		
F9999	FINAL OBSERVATIONS Based on observation, record review, staff interview, and family interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		