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	355031	A. BUILDING _____ B. WING _____	07/26/2017

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MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 07/24/17 and completed on 07/26/17, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 157		8/28/17

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

Electronically Signed | 08/11/2017

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F 157	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure notification of the health care provider for 1 of 1 sampled resident (Resident #7) regarding medication held for numerous days. Failure to notify the resident's health care provider when holding Lasix (fluid medication) for numerous days limited the physician's ability to make an informed decision regarding the resident's care. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included hypertension. The physician's orders dated 06/07/17, stated, Lasix 20 milligrams two times a day and hold if blood pressure is less than	F 157	Resident #7 was seen by his physician on July 6, 2017 who was updated on Lasix being held based on parameters established by the physician and the Lasix was discontinued at that time. Resident no longer has medications that are being held. Residents who have medications held based on parameters set by the physician and those who refuse medications have the potential to be impacted by this practice. MARs were reviewed to identify like residents and physicians were updated when indicated. Medication Management guidelines were revised to include notification of medical provider	

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F 157	Continued From page 2 110/60. Review of Resident #7's medication administration record identified from 06/08/17 until 07/06/17 staff held Resident #7's Lasix 50 times due to a blood pressure less than 110/60. The medical record failed to identify staff notified the resident's physician. During an interview on 07/26/17 at 11:00 a.m. an administrative nurse (#3) stated she would expect staff to notify the physician when holding medication that frequently.	F 157	when a medication is held or refused for two consecutive days. The DON or designee provided education\will provide education on physician notification of held or refused medications to nurses on August 9th and 15th. Medications that are held or refused for two consecutive days will be reported to the medical provider. The DON or designee will complete audits of MAR for held or refused medications and validate notification of medical provider three times weekly for four weeks then two times weekly for four weeks then weekly for four weeks then monthly for three months. Results of audits will be submitted to QAPI committee for review and recommendations. Audits will be initiated the week of August 14, 2017.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274		8/28/17

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F 274	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 13 sampled residents (Resident #3) reviewed. Failure to determine the need for and complete a SCSA in response to the resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page 2-22 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . ." Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/11/17, identified: * walking in room did not occur * extensive assistance with locomotion on the unit * extensive assistance with locomotion off the unit * frequently incontinent of bowel	F 274	A significant change assessment with an ARD of 08/07/2017 is being completed for resident #3. CAAs are due for this assessment on 08/14/2017 and additional updates to care plan will be made if indicated when this process is complete. Residents who experience of a change of condition that is not related to a short term self limiting condition have the potential to be impacted by this practice. Changes of condition are now tracked and trended during the interdisciplinary team meeting and discussion is held on whether or not a significant change MDS assessment is indicated. Reference material from pages 2-20 to 2-27 of the RAI manual have been printed and are now available for review during the interdisciplinary meeting. The DON reviewed pages 2-20 through 2-27 with the Resident Assessment Coordinator on August 3, 2017. Review of this same reference was completed with the interdisciplinary team on August 11, 2017 by the DON and the Resident Assessment Coordinator. The DON or designee will complete audits of the change in condition tool and validation that significant change assessments have been initiated and completed three times weekly for four weeks then two times weekly for four weeks then weekly for four weeks then	

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F 274	Continued From page 4 * one unstageable pressure ulcer The admission MDS, dated 01/19/17, identified the following changes: * limited assistance with walking in room * supervision with locomotion on the unit * supervision with locomotion off the unit * occasionally incontinent of bowel * no pressure ulcers The facility failed to complete a SCSA following Resident #3's decline in four areas, plus the development of a pressure ulcer.	F 274	monthly for three months. Results of audits will be submitted to QAPI committee for review and recommendations. Audits will be initiated the week of August 14, 2017.	
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		8/28/17

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F 280	Continued From page 5 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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 280		

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F 280	Continued From page 6 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/12/17. Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 4 of 13 sampled residents (Resident #2, #3, #4, and #13). 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 Resident #2's medical record occurred on all days of survey. The record included a fax from the physician, dated 06/22/17, which stated, ". . . Thank you for the update. Please advance diet to regular textured diet . . ." The record also included a fax to the physician, dated 07/05/17, which requested the use of Prevalon (pressure-reducing) boots at	F 280	Resident #2,#3,#4, and #13 care plans were updated as staff were made aware of concerns noted during survey. In depth reviews for these residents and further updates were completed between August 1-4 by nurse managers. Residents who have changes in their plan of care, require oxygen use, wear hearing aides or need other personalized approaches have the potential to be impacted by this practice. These residents were identified through direct observation and chart review. Care plans were updated to reflect current needs when indicated. The audit form for reviewing changes in condition during the morning clinical meeting was revised to include an area for validation care plans are updated as changes occur. The DON provided education on care	

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F 280	Continued From page 7 night. The physician responded, "yes, agree [with] above." Review of Resident #2's care plan on 07/24/17 identified a mechanical soft diet and failed to include the use of Prevalon boots. Observations throughout the survey showed staff served Resident #2 a regular textured diet. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD). Physician's orders included oxygen and nectar thick liquids. Medications included Doxepin and Melatonin at bedtime to facilitate sleep. Nurses' notes, reviewed from 01/12/17 to 07/25/17, stated Resident #3 failed to sleep well on multiple occasions. A nurse's note, dated 05/03/17, stated, ". . . not slept . . . Dr (doctor) increased the Melatonin from 5 to 10 mg [milligrams]. . . . Dr wants psych evaluation for anxiety and insomnia." The current care plan stated, ". . . Focus: Resistive/noncompliant with treatments/cares. On Honey Thickened liquids. . . . Focus: At risk for nutritional status change . . . Nectar thick liquids . . ." Observation throughout the survey showed Resident #3 wore bilateral hearing aids and received oxygen at 2 liters per minute (L/min) per nasal cannula. During an interview on the afternoon of 07/26/17, an administrative nurse (#3) verified Resident #3's care plan failed to include the use of hearing	F 280	plan updates and personalization of care to nurse managers on August 1, 2017. The DON or designee provided/will provide education regarding the care plan process in the electronic health record to licensed nurses on August 9th and August 15th. Education included the need for personalization and revisions based on the changing needs of the resident. The DON provided information on required updates to the interdisciplinary team on August 11, 2017. Care plans will be audited for updates during the morning clinical meeting by the the interdisciplinary team. Validation of audits and completion of updates to care plans will be completed by the DON or designee three times weekly for four weeks, then two times weekly for four weeks, then weekly for four weeks, then monthly for three months. Results of audits will be submitted to the QAPI committee for review and recommendation. Audits will be initiated the week of August 14, 2017.	

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F 280	Continued From page 8	F 280		

aids and oxygen, and was inconsistent regarding thickened liquids.

Resident #3's care plan failed to include problems and/or interventions related to hearing aids, oxygen, and insomnia. The care plan stated inconsistencies related to thickened liquids.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included pathological fracture of the right femur, and osteoarthritis.

A physical therapy plan of care, dated 06/29/17, identified, ". . . Weight bearing status, right LE [lower extremity] . . . current level . . . non weight bearing . . . Transfers, bed/chair . . . total assist (100% assist) . . ."

The current certified nursing assistant (CNA) kardex, dated 07/26/17, identified ". . . Transfer with full body sling and full mechanical lift and two staff. Use care with moving right leg. Immobilizer to remain in place at all times."

The current care plan stated, ". . . At risk for falls due to weakness, history of falls . . . Provide assist to transfer and ambulate as needed . . . Immobilizer to remain in place at all times . . . Ostomy r/t [related to] . . . impaired mobility, loss of bladder muscle tone . . ."

During an interview on 07/25/17 at 2:40 p.m., a physical therapy manager (#5) verified Resident #4 is currently unable to ambulate due to a fracture of the right femur.

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F 280	Continued From page 9 During an interview on 07/26/17 at 2:00 p.m., an administrative staff member (#3) verified Resident #4's care plan focus/intervention regarding ambulation, and ostomy is not appropriate and staff need to update the care plan. The facility failed to review and revise the comprehensive care plan to reflect the resident's current status. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease. A quarterly Minimum Data Set (MDS), dated 05/13/17, identified moderately impaired cognition and oxygen use. The current physician order, dated 06/26/17, identified, "oxygen @ 2L/NC [liters per nasal cannula] to maintain O2 [oxygen] SATS [saturation level] check each shift." Review of Resident #13's care plan on 07/26/17 showed the facility failed to include the focus and interventions for the oxygen. Observations on 07/26/17 showed: * 12:15 p.m., Resident #13 sat in the wheel chair in the dining room with continuous oxygen on at 2L/NC. * 2:05 p.m., Resident #13 laid in bed with continuous oxygen on at 3L/NC. During an interview on 07/26/17 at 2:00 p.m., an administrative staff member (#3) verified Resident #13's care plan failed to include the	F 280		

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F 280	Continued From page 10 focus and/or interventions related to the oxygen.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (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: MEDICATION VIA GASTROSTOMY TUBE 1. Based on observation, record review, review of facility policy, and staff interview, facility staff failed to provide care and services according to professional standards for 1 of 1 sampled resident (Resident #8) observed receiving medications via gastrostomy (g-tube). Failure to flush the g-tube between medications may affect the efficacy of the medications. Findings include: Review of the facility policy titled, "Administering Medications through an Enteral Tube" occurred on 07/26/17. This policy, not dated, stated, ". . . Equipment and Supplies . . . 26. If administering more than one medication, flush with 15 ml [milliliters] (or prescribed amount) warm sterile or purified water between medications. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included quadriplegia and malnutrition. Liquid medications included lactulose (laxative) and UTI	F 281	Resident #7 did not experience signs or symptoms of hypoglycemia following insulin administration. Resident #8 has had no complications with function of enteral tube related to the administration of medication. The nurse involved in administering medications via enteral tube to resident #8 and administering insulin to resident #7 was educated by the DON on the process for enteral tube medication administration and insulin administration. Validation of skill for this nurse was completed through direct observation by unit manager. Resident #6 was discharged on July 27, 2017. Residents who receive medication via enteral tube, those that require fast acting insulin, and those with order changes have the potential to be impacted by this practice. Like residents were identified through chart review and direct observation. A copy of "Action Times for Insulin" was added to each MAR for quick reference by nurses. Instructions to flush	8/28/17

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F 281	Continued From page 11 (Urinary Tract Infection) Heal (cranberry supplement). Observation on 07/25/17 at 9:20 a.m. showed a licensed staff nurse (#7) checked placement of Resident #8's g-tube and administered lactulose mixed in 120 cubic centimeters (cc) of water, and without flushing the g-tube with water, the nurse administered the UTI Heal mixed in 120 cc of water. During an interview on 07/26/17 at 11:00 a.m., an administrative nurse (#3) stated she would expect staff to flush the g-tube with water between medications. INSULIN ADMINISTRATION 2. Based on observation and review of professional reference, the facility failed to follow professional standards of practice regarding insulin administration for 1 of 3 residents (Resident #7) observed receiving rapid-acting insulin. Failure to ensure food is offered within the recommended time frame after insulin administration may result in hypoglycemia (low blood sugar). Findings include: The "Nursing 2017 Drug Handbook," 37th Edition, Wolters Kluwer, Pennsylvania, pages 789-790 stated, ". . . NovoLog . . . (5 to 10 minutes) before a meal. . . ." Observation on 07/24/17 at 5:25 p.m. showed a licensed staff nurse (#7) administered 4 units of NovoLog insulin to Resident #7. Resident #7 sat	F 281	enteral tube between each dose of medication was added to the MAR for identified residents. A policy for enteral tube medication administration was received from the consultant pharmacist and includes flushing enteral tube with 5 cc of water between each dose of medication. The facility nurses routinely notify the pharmacy of changes in orders and continue to notify pharmacy via fax of all new orders and order changes. A new step has been added to the medication guideline that includes applying a sticker to medications that have a dosage change or time interval change that sate "Directions have Changed, Refer to Chart". Accuracy of transcription of orders is now validated by night shift nurses and rechecked by unit managers. The DON or designee provided\will provide education to licensed nurses on August 9th and August 15th. Education included insulin action times and professional standards for insulin administration, enteral tube medication administration, transcription of orders, affixing "Directions have Changed, Refer to Chart" stickers to medication labels. Importance of accurate transcription of orders and validation of transcription was also reviewed with nurses. The DON or designee will complete audits through direct observation of administration of medications through enteral tubes and administration of insulin. The unit managers will audit new	

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F 281	Continued From page 12 at the dining room table with only a glass of water until 6:02 p.m. when he received his meal tray (37 minutes later). MEDICATION TRANSCRIPTION 3. Based on observation, record review, review of facility policy and review of professional reference, the facility failed to ensure accurate transcription of medication orders for 1 of 13 sampled residents (Resident #6). Failure to ensure the medication administration record (MAR) and medication label contain the same information as the physician's order may lead to medication errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education Inc., New Jersey, page 761, stated, ". . . Communicating a Medication Order . . . A drug order is written on the client's chart by a primary care provider or by a nurse receiving a telephone or verbal order from a primary care provider. . . . The nurse or clerk then copies the medication order to a Kardex or medication administration record (MAR). . . . CLINICAL ALERT . . . If your assigned client receives new medication orders, double-check the transcribed information with the primary care provider's order. This ensures client safety. . . ." Review of the facility policy titled "Labeling of Medication Containers" occurred on 07/26/17. This policy, revised April 2007, stated, ". . . Any medication packaging or containers that are	F 281	orders routinely and the DON or designee will complete random audits of accuracy of transcribed orders and validate alert stickers have been placed on labels of medications with order changes. Audits of these standards will be completed three times weekly for four weeks, two times weekly for four weeks, once weekly for four weeks, and then monthly for three months. Audits will be submitted to the QAPI committee for review and recommendation. Audits will be initiated the week of August 14, 2017.	

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F 281	Continued From page 13 inadequately or improperly labeled shall be returned to the issuing pharmacy. . . . The nursing staff must inform the pharmacy of any changes in physician orders for a medication. . . ." Review of Resident #6's medical record occurred on all days of survey. A physician's order, dated 07/21/17, stated, "Norco [a pain reliever] 5 mg [milligrams] - 325 mg oral tablet . . . Instructions: 0.5 [one half] tab [tablet] q8h [every eight hours] PRN [as needed] for severe pain. . . ." Review of Resident #6's July MAR showed a hand written entry, dated 07/22/17, that identified Norco 5 mg - 325 mg every eight hours for severe pain. The MAR failed to identify the correct dose of half a tablet. Observation of the medication cart on the afternoon of 07/25/17 showed Resident #6's Norco contained a label on the package which identified the frequency as twice per day, not every eight hours as ordered on 07/21/17. Failure to ensure the MAR and medication label accurately reflect the physician's order may result in medication errors.	F 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323		8/28/17

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F 323	Continued From page 14 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure adequate supervision and assistive devices to prevent accidents for 1 of 2 sampled residents (Resident #4) who required extensive assistance with transfers using a mechanical lift. Failure to use the proper transfer lift sling and provide adequate supervision with transfers/cares placed the resident at risk for sustaining a fall or injury. Findings include: Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included pathological fracture of the right femur and osteoarthritis. The significant change Minimum Data Set (MDS), dated 06/23/17, identified severely impaired cognition and	F 323	A skin assessment was completed for resident #4 on July 26, 2017 and no new skin alterations were noted related to transfer. Resident #4 has had effective pain management and has not had increased complaints of pain related to transfer with the incorrect sling. Resident #4 was seen by the orthopedist on August 1, 2017 and the spontaneous fracture has healed and immobilizer has been discontinued. The correct sling for transfers is available in the resident's room. CNAs who routinely care for resident #4 received verbal education on the importance of using the correct sling and using care when moving her right leg on July 26 and July 27.	

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F 323	Continued From page 15 extensive assistance of two for transfers. Review of the physical therapy plan of care, dated 06/29/17, identified, ". . . Transfers, Bed/Chair . . . total assist (100%) . . ." The current care plan identified, ". . . Pathological fracture right . . . femur . . . NWB [nonweight bearing] to right leg . . . Transfer with full body sling and full mechanical lift and two staff. Use care with moving right leg. Immobilizer to remain in place at all times . . ." Review of the certified nursing assistants (CNA's) kardex, dated 07/26/17, identified, ". . . transfer with full body sling and full mechanical lift and two staff. Use care with moving right leg. Immobilizer to remain in place at all times." Observation on 07/24/17 at 3:10 p.m., showed two CNAs (#8 and #9) entered Resident #4's room, completed cares and placed a partial lift sling underneath her. The CNA (#9) pulled Resident #4's right leg outward to the side while she lay in bed. The resident yelled out, "ouch ouch," when the CNA (#9) pulled the transfer sling straps up between her legs. The CNA (#8) raised Resident #4 up off the bed with the mechanical lift. Resident #4's right leg hung down with the immobilizer on it and she yelled out, "ouch ouch," as the CNA (#9) lowered her down into the wheel chair/recliner. The facility staff failed to transfer Resident #4 with the full body sling and support the right leg during the transfer. Observation on 07/25/17 at 8:05 a.m., showed two CNAs (#10 and #11) placed a partial lift sling underneath Resident #4 and transferred her from	F 323	Residents who require total mechanical lifts for transfers have the potential to be impacted by this practice. Residents were identified through direct observation and chart review. The type of sling required for each resident was identified and availability of sling in resident's room was validated. The DON or designee provided/will provide education to CNAs and licensed nurses on August 9th and 15th on types of slings and the use of Kardex to identify if a specialty sling is required for the care of a resident. Education included the importance of providing care in a manner that protects extremities when repositioning resident to apply or remove the lift sling. Direct observation of transfers with full mechanical lifts will be completed by the DON or designee three times weekly for four weeks, then two times weekly for four weeks, then weekly for four weeks, then monthly for three months. Results of audits will be forwarded to QAPI committee for review and recommendations. Audits will be initiated the week of August 14th.	

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F 323	Continued From page 16 the bed to the reclining wheel chair with a mechanical lift. During the transfer, the resident grimaced and moaned aloud. The CNA (#11) stated, "I think we used the wrong lift sheet on this resident." The CNA (#11) left the room and returned with a full body lift sling. The CNAs (#10 and #11) transferred Resident #4 from the reclining wheel chair back to the bed with the partial lift sling mechanical lift and her right leg hung down with the immobilizer on. The facility staff failed to transfer Resident #4 with the proper lift sling and support the right leg during the transfer. During an interview on 07/25/17 at 8:30 a.m., a CNA (#11) verified Resident #4 should be transferred with the full body lift sling to keep her legs together and support provided to the right fractured leg. During an interview on 07/26/17 at 2:00 p.m., an administrative staff member (#3) verified Resident #4 should be transferred with a full body lift sling.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance,	F 325		8/28/17

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F 325	Continued From page 17 unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (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: Based on observation, record review, and staff interview, the facility failed to maintain acceptable nutritional status for 1 of 3 residents (Resident #2) identified with weight loss. Failure to consistently implement weight loss interventions may result in poor nutrition and avoidable weight loss. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dysphagia and dementia without behaviors. The current Minimum Data Set (MDS), dated 05/09/17, identified extensive assistance from one person for eating. Resident #2's care plan stated, ". . . At risk for nutritional status change r/t [related to] wt. [weight] loss. Intakes less than estimated need . . . Interventions . . . assist to consume foods and/or supplements and fluids offered . . . " A dietary assessment, dated 05/09/17, stated, ". . . Visited with [Resident #2] and spouse about preferences. . . . Her UBW [usual body weight] 150#. . . . She dislikes; all potato but French fries, all vegetables except green beans and corn . . ." Dietary progress notes stated the following:	F 325	The food services manager and dietitian reviewed diet recommendations for resident #2 and validated that fortified foods are offered at breakfast and supper as recommended. Direct caregivers were verbally reminded following survey exit of the need to offer assistance in a timely manner when meals are served and the need to deliver, assist with intake of, document intake of, and report refusals of supplemental snacks. Residents who have the potential for weight loss or who need assistance with meal or snack intake have the potential to be impacted by this practice. Like residents were identified through direct observation and chart review. Guidelines for interventions for unintended weight loss were developed and are being implemented. The DON or designee provided or will provide education to the nurses and CNAs on August 9 and August 15, 2017. Guidelines were reviewed and process for accurately documenting meals and snacks was reviewed with nursing staff. The importance of providing assistance	

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F 325	Continued From page 18 *05/23/17 at 1:58 p.m.: ". . . Fortified cereal daily and fortified soup at supper. . . Staff set up and assist her at meals. . . ." *06/04/17 at 10:49 a.m.: ". . . receiving fortified items at meals for additional nutrition and finger foods offered as much as possible. Recent weight loss is noted. Review weight 140, will add high calorie snacks at 10 am and 3 pm. Will continue to provide a fruit cup at hs [bedtime] per her request. . . ." *07/11/17 at 10:01 a.m.: ". . . Fortified pudding at 10 AM provides approx. [approximately] 250 calories and 6 gms [grams] pro. [protein] Ice cream at 3 PM and fruit cup at HS per her request. . . ." *07/11/17 at 3:03 p.m.: ". . . Current wt. 133.6# 3% loss in 1 month. Continues to lose wt. . . . Continue fortified items and supplements. Try fortified mashed potato. . . ." Resident #2's dietary assessment, dated 05/09/17, identified the resident did not like potatoes. *07/25/17 at 11:33 a.m.: ". . . receiving fortified items at meals for additional nutrition and high calorie snacks between meals. . . . Refused fortified potatoes tried last week. . . . Refuses approximately 75% of snacks. . . ." Resident #2's weight records identified a weight of 156.4 pounds (lbs) on 05/02/17, and a current weight on 07/24/17 of 133 lbs. This represents a 23.4 lb (15%) weight loss over twelve weeks. Observation on 07/24/17 at 3:45 p.m. showed Resident #2 asleep in her bed. An unopened container of ice cream sat on her bedside table. At 4:55 p.m., observation showed the resident out of bed and in her wheelchair, and the container of ice cream in the garbage with the lid	F 325	with meal and snack intake was included in the education provided as well.. Direct observation of assistance with meal intake and validation of snacks and assistance being offered and documented will be completed by the DON or designee three times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks, then monthly for three months. Results of the audits will be forwarded to the QAPI committee for review and recommendations. Audits will be initiated the week of August 14th.	

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F 325	Continued From page 19 still on. Snack intake charting for the afternoon of 07/24/17 failed to show a snack offered to Resident #2. Observation of the evening meal on 07/24/17 showed Resident #2 received her tray at 6:10 p.m. Staff failed to assist the resident with the tray set up, including removing the lid from her bowl of soup or unwrapping her silverware. The resident made no attempt to feed herself and received no cuing from staff until 6:21 p.m. when a staff member sat by the resident and assisted her to eat. Observation during the noon meal on 07/25/17 showed staff served Resident #2 a piece of fish, mixed vegetables (containing vegetables the resident identified she did not like), diced peaches, and eight ounces of milk. The meal failed to contain any fortified items and was the same food served to other residents. Review of Resident #2's snack intake records showed from 06/05/17 through 07/25/17, staff failed to document the 10:00 a.m. snack nine times and the 3:00 p.m. snack 38 times. Failure to accurately record snack intakes/refusals may misrepresent the actual amounts consumed by Resident #2 and may delay further dietary intervention. During an interview on the morning of 07/26/17, a supervisory nurse (#10) agreed the snack intakes were not accurately recorded and that Resident #2 needed assistance with meals.	F 325		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		8/28/17

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F 328	Continued From page 20 (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure	F 328		

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F 328	Continued From page 21 that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 2 of 5 sampled residents (Resident #4 and #13) receiving oxygen therapy. Failure to follow the physician's orders and provide guidance to facility staff on oxygen usage does not allow the facility or the health care provider to assess the effectiveness of the resident's oxygen therapy. Findings include: Berman and Snyder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1259 states, ". . . 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	F 328	Resident #4□s care plan was revised on 07/26/17 to include oxygen use and upon learning the oxygen had not been applied staff ensured oxygen was applied as ordered. MD ordered oxygen discontinued for Resident #4 on 08/11/17 and used only PRN for O2 sats less than 90% as resident□s last respiratory related hospitalization was more than a year ago on 07/18/2016. O2 sats will be recorded each shift on room air for one week then transitioned to PRN. The care plan was revised on 08/11/17 to include this order update. The concentrator for Resident #13 was set to the proper liter flow when surveyors made staff aware of this finding Residents who use supplemental oxygen have the potential to be affected by this practice. Residents were identified through record review and direct	

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F 328	Continued From page 22 condition. . . ." Review of the facility policy titled "Oxygen Administration" occurred on 07/26/17. This policy, dated October 2010, stated, ". . . Review the physician's orders or facility protocol for oxygen administration. . . . Adjust the oxygen delivery device so that . . . the proper flow of oxygen is being administered. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included congestive heart failure (CHF), hypoxia (low blood oxygen), pleural effusion (collection of fluid next to the lung), pneumonia, and pulmonary edema. The significant change Minimum Data Set (MDS), dated 06/23/17, identified severely impaired cognition and oxygen use. The current care plan identified, ". . . O2 [oxygen] on at 2L/min [liters per minute] via nasal cannula to keep sats [oxygen saturation] > [greater than] 90%. Monitor O2 SATS q [every] shift. . . . respiratory impairment related to: history of hospitalization for pneumonia, pulmonary edema . . . evaluate lung sounds and VS [vital signs] . . ." A current physician order, dated 06/29/17, identified, "oxygen @ 2L/MIN via NC [nasal cannula] to keep O2 SATS > 90%. Monitor SATS every shift." A progress note, dated 07/18/17, stated, ". . . Admitted to hospital . . . hypoxia . . . left sided pleural effusion . . ." The Treatment Administration Record (TAR) and	F 328	observation. Care plans were updated to reflect oxygen use when indicated. MARS were updated to include sign offs for the use of oxygen, validation of liter flow setting, and documentation of O2 sats. Oxygen guidelines were reviewed and revised by the DON. MARS for residents who use supplemental oxygen have been updated to include sign offs for the use of oxygen, validation of liter flow setting, and documentation of O2 sats. The DON or designee provided/will provide education to nurses and CNAs on oxygen guidelines and documentation of oxygen use on August 9th and August 15th 2017. The DON or designee will complete audits for compliance with doctor□s orders for oxygen use and validation of proper documentation of oxygen use three times weekly for four weeks, two times weekly for four weeks, weekly for four weeks and monthly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 328	Continued From page 23 weights and vitals summary, dated July 01-24, 2017, identified no documentation on Resident #4's oxygen usage for the following dates/times: * 07/02/17 day shift * 07/06/17 night shift * 07/11/17 day shift * 07/20/17 night shift * 07/21/17 day and night shift Observations showed the following: * 07/24/17 at 10:20 a.m., Resident #4 laid in bed without oxygen on. Staff failed to continuously provide oxygen to Resident #4. * 07/24/17 at 3:55 p.m., two certified nursing assistants (CNAs) (#8 and #9) provided perineal cares for Resident #4. One CNA (#8) removed the oxygen nasal cannula tubing from the resident and then the two CNAs (#8 and #9) transferred Resident #4 into her wheel chair/recliner. One CNA (#8) asked Resident #4 if she wears oxygen when she is up in the chair. Resident #4 stated she was unsure. The CNA (#8) shut off the oxygen concentrator and both CNAs exited the room. The CNA failed to clarify with a staff nurse if Resident #4 required oxygen continuously. * 07/24/17 at 5:40 p.m. and 6:00 p.m.., Resident #4 sat in the wheel chair/recliner in the dining room without oxygen on. * 07/25/17 at 8:05 a.m., two CNAs (#11 and #12) entered Resident #4's room, removed the oxygen nasal cannula from the resident, shut off the oxygen concentrator, transferred her from the bed to the wheel chair/recliner, and brought her to the dining room. The CNAs failed to reapply the oxygen. * 07/25/17 at 8:50 a.m. and 9:20 a.m., Resident sat in wheel chair/recliner without oxygen on.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	07/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 328	Continued From page 24 * 07/25/17 at 11:55 a.m., two CNAs (#11 and #13) entered Resident #4's room, removed the oxygen nasal cannula tubing from the resident, shut off the oxygen concentrator, transferred her from the bed to the reclining wheelchair, and exited the room. The CNAs failed to reapply the oxygen. * 07/25/17 at 12:25 p.m., Resident #4 sat in the wheel chair/recliner in the dining room without oxygen on. * 07/26/17 at 11:07 a.m., Resident #4 laid in bed without oxygen on. A CNA (#15) and a staff nurse (#16) entered Resident #4's room, provided wound cares, and then exited the room. The facility staff failed to apply and provide oxygen to Resident #4. 07/26/17 at 12:00 p.m., 1:00 p.m., and 2:00 p.m., Resident #4 laid in bed without oxygen on and the oxygen concentrator turned off. During an interview on 07/25/17 at 11:30 a.m., a nurse manager (#14) confirmed staff should ensure Resident #4's oxygen is administered at 2L/MIN and on at all times per nasal cannula. Resident #4's oxygenation levels drop down to 80% when the oxygen is not administered continuously. The nurse manager (#14) stated she expects the staff nurse to document oxygen use for Resident #4 every shift. During an interview on 07/26/17 at 2:00 p.m., an administrative staff member (#3) verified staff are expected to ensure the consistency in delivery of Resident #4's oxygen at 2L/NC continuously. The facility failed to consistently provide Resident #4's oxygen. - Review of Resident #13's medical record	F 328		

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F 328	Continued From page 25 occurred on all days of survey. Diagnoses included Parkinson's Disease. A quarterly MDS, dated 05/13/17, identified moderately impaired cognition and oxygen use. A current physician order, dated 06/26/17, identified, "oxygen @ 2L/NC to maintain O2 SATS check each shift." Observations on 07/26/17 showed: * 12:15 p.m., Resident #13 sat in a wheel chair in the dining room with continuous oxygen on at 2L/NC per portable oxygen tank. * 2:05 p.m., Resident #13 laid in bed with continuous oxygen on at 3L/NC per oxygen concentrator. During an interview on 07/26/17 at 2:00 p.m., an administrative staff member (#3) verified staff are expected to ensure the consistency in delivery of Resident #13's oxygen at 2L/NC continuously. The facility failed to consistently provide Resident #13's oxygen at the ordered flow rate.	F 328		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		8/28/17

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F 431	Continued From page 26 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (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. (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.	F 431		

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F 431	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, facility record review, and staff interview, the facility failed to ensure proper labeling and storage/disposal of medications on 3 of 3 days of survey (July 24-26, 2017). Failure to ensure correct labeling of insulin pens (4 observations), lock an unattended medication cart (North Cart Second Floor), and properly dispose of a fentanyl patch (narcotic pain patch) may result in medication errors and allow access of unauthorized personnel, visitors, and/or residents to medications. Findings Include: LABELING OF MEDICATION Review of the facility policy titled "Labeling of Medication Containers" occurred on 07/26/17. This policy, dated April 2007, stated, ". . . 9. The nursing staff must inform the pharmacy of any changes in physician orders for a medication." - Observation during a medication pass on 07/24/17 at 5:25 p.m. showed a licensed staff nurse (#7) administered Novolog 4 units, as stated on the Medication Administration Record (MAR), to Resident #7. The medication label stated, inject 5 units subcutaneously three times a day. The current physician orders, dated 07/06/17, stated, decrease Novolog to 4 units three times daily with meals. The facility failed to update the medication label to coincide with the physician's order. - Observation on 07/25/17 at 8 a.m. showed a licensed staff nurse (#7) administered 20 units of	F 431	Nurses on duty were counseled on locking and securing medication carts prior to leaving the cart unattended upon survey exit. A meeting was held with staff on August 1, 2017 and initial findings from survey were reviewed including the importance of securing medication carts. A conversation was held with the facility□s consultant pharmacist on August 1, 2017 to explore solutions to labeling medications. Nurses were reminded on July 26 to dispose of transdermal patches in a sharps or medication destruction solution and not in the garbage. Residents in the facility have the potential to be affected by these practices. Guidelines for storage and security of medication were developed and will be fully implemented by August 16, 2017. New guidelines for removal and disposal of transdermal fentanyl patches were received from the corporate office and will be implemented by August 16, 2017. New guidelines for placing an alert label on the pharmacy labels that instructs nurses directions have changed-see chart and these will be placed by nurses when new orders are received that change administration of existing medication. These labels were requested from pharmacy on August 9, 2017 and will be implemented on August 16, 2017 following nursing staff meetings. Staff continues to notify pharmacy of	

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F 431	Continued From page 28 Levemir insulin, as stated on the MAR, to Resident #7. The medication label stated, inject 30 units subcutaneously. The current physician order dated 07/08/17, stated, decrease Levemir to 20 units. The facility failed to update the medication label to coincide with the physician order. An interview occurred on 07/24/17 during the medication pass; a licensed nurse (#7) stated when an insulin dose changes pharmacy does not change the label. - Observation during a medication pass on 07/25/17 at 8:46 a.m. showed a staff nurse (#1) administered Levemir insulin 15 units, as stated on the MAR, to Resident #16. The medication label stated inject 10 units subcutaneously at bedtime. The current physician orders, dated 07/03/17, stated, increase Levemir insulin to 15 units subcutaneously twice a day. The facility failed to update the medication label to coincide with the physician's order. On 07/26/17 at 9:45 a.m. two staff nurses (#1 and #2) identified nursing staff should contact the pharmacy to get new labels for the insulin when the order is changed. STORAGE OF DRUGS Review of the facility policy titled "Administering Medications" occurred on 07/26/17. This policy, revised December 2012, stated, ". . . During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. . . ."	F 431	medication changes via fax as is the standard of practice in the facility. New supplies of medication have revised labels on them when sent for pharmacy cart change over. The DON or designee provided education to nurses regarding the storage and security of medication, disposal of transdermal fentanyl patches, and placing labels on medications with changes on August 9th and will complete a second meeting on August 15, 2017. The DON or designee will complete audits through direct observation and documentation review three times weekly for four weeks, two times weekly for four weeks, one time weekly for four weeks and then monthly for three months. Audits will include security of medication carts, labeling of medications with direction changes, and disposal of transdermal patches. Audits will be implemented the week of August 14, 2017	

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F 431	Continued From page 29	F 431		

Observation on 07/24/17 at 5:21 p.m. showed an unlocked medication cart on the north hallway of the 2nd floor, and the nurse seated at the nurses' station (not in view of the cart). Observations at 5:27 p.m., 5:39 p.m., 5:46 p.m., and 5:53 p.m. showed the cart remained unlocked and the nurse was not in view of the cart. Observation at 6:02 p.m. showed the cart locked.

DISPOSAL OF MEDICATION

Review of the facility policy titled, "Administering Topical Medications" occurred on 07/26/17. This policy, dated October 2010, stated, ". . . Trans-dermal patches . . . Discard all disposable items into designated containers. . . ."

Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included pathological fracture of the right femur and osteoarthritis. The current physician's order, dated 06/29/17, identified "Fentanyl 12 MCG [micrograms]/HR [hour] patch. Apply 2 patch [sic] every 3 days for pain. Check placement daily. Discard old patch."

Observation on 07/25/17 at 3:40 p.m. showed a staff nurse (#6) applied gloves, removed a Fentanyl patch (trans-dermal patch) from the right side of Resident #4's chest, disposed of it in the garbage can next to the resident's bed, and exited the room.

During an interview on 07/26/17 at 8:45 a.m., an administrative staff member (#3) verified she expected staff to dispose the trans-dermal patch in the sharps container located on the medication cart along with another nurse to witness the

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F 431	Continued From page 30 disposal of the patch.	F 431		