STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 02/21/16 and completed on 02/24/16, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		3/23/16

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

Electronically Signed | 03/21/2016

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/22/15. Based on record review, review of facility policy, and staff interview, the facility failed to ensure timely health care practitioner and family notification for 2 of 2 sampled residents (Resident #8 and #10) who sustained a fall with injury and a low blood pressure. Failure to promptly notify the health care practitioner of a medication error, the family of a fall with injury (Resident #8) and notify the physician of a fall and a low blood pressure (Resident #10) may have delayed treatment. Findings include: Review of the facility policy titled "Notification of Change" occurred on 02/23/16. This policy, dated 09/04/14, stated, "Purpose: To immediately inform the resident, consult with the resident's physician, and notify the resident's legal representative or an interested family member when there is a change. Procedure: The following warrant a need to notify the resident, resident's physician, and the resident's family . . . 1. An accident involving the resident which results in injury and has the potential for requiring physician intervention. 2. A significant change in the resident's physical, mental, or psychosocial status. These changes may include a	F 157	1. Corrective action taken for resident #8 was that the nurse was educated on the policy of notifying family/family representative and physician promptly after an adverse event occurs. No corrective action is indicated for resident #10 because the facility is unable to change past events. 2. The facility has identified that all residents have the potential to be affected by the same deficient practice. 3. The facility has developed a Physician Notification Form (attachment#1) that will be faxed to the physician to notify them of events that may occur with residents who do not need immediate medical attention. Forms were initiated on 3/2/16. The facility reviewed the Notification of Change policy (attachment #2) and reviewed the updated Medication Error #3) and Resident Falls policies(attachment #4) . Education was provided to nurses on 3/1/16 (attachment #9) and 3/16/16 (attachment #10) on the Notification of Change, Medication Error, and Resident Fall policies. Education was also provided on 3/16/16 on appropriate documentation (attachment #21). A handout from the American Society of Registered Nurses (attachment #5) was also distributed and reviewed on 3/16/16.	

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F 157	Continued From page 2 deterioration in health, mental, or psychosocial status. . . ." Review of the facility policy titled "Medication Error" occurred on 02/23/16. This policy, dated 09/07/14, stated, "Medication error: . . . Significant medication error caused the resident discomfort or jeopardizes his or her health and safety. Examples are: 1. Omissions 2. Unauthorized drugs (drugs administered without a physician's order) . . . Any medication error must be reported to the resident's attending physician . . . 3. Depending on the severity of the error, the medications the resident should have received may be held until the physician is updated. . . ." Review of the facility policy titled "Resident Falls" occurred on 02/23/16. This policy, dated 09/07/14 stated, ". . . Procedure: . . . 2. Doctor is to be notified if injury is noted or suspected. . . ." During an interview on 02/22/16 at 5:02 p.m. an administrative nurse (#1) stated on 11/30/15 before Resident #8 sustained a fall a medication error had occurred. (Refer to F333) - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included insulin dependent diabetes, and hypertension (high blood pressure). Medications included Lantus insulin (long acting insulin), Coumadin (blood thinner) daily, Tramadol (narcotic like pain medication) twice daily, Tylenol extra strength (mild discomfort) and metoprolol (to lower blood pressure). Nursing progress notes stated the following:	F 157	4. The facility has corrected the deficient practice as of 3/16/16. 5. The Director of Nursing or designee(s) will conduct a QA on medication administration for 4 residents weekly X 4 weeks, monthly X 3, and quarterly X 3. A QA will also be completed on 4 change of resident events requiring physician and family notification to ensure that proper notification is given according to facility Notification of Change policy weekly X 4, monthly X 3, then quarterly X 3. And finally, a QA will be completed on reviewing nursing documentation for all residents weekly X 4 weeks, monthly X 3, then quarterly X 3. All will be reevaluated for further monitoring or interventions.	

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F 157	Continued From page 3 * 12/01/2015 1:58 AM - regarding an event that occurred on 11/30/15 at 9:15 p.m. - "CNA was calling this nurse over handset to go to resident room. Observed resident in supine position and stated that she got up and was about to lower her window blinds when she felt dizzy and lost her balance, she added she hit the back of her head. Room is crowded with furniture and resident has gripper socks on. No swelling or redness back of her head [sic], ROM [range of motion] ok, upper and lower extremities has no pain upon moving and equal in length. Voiced #6 pain to back of head and lower back pain and with some dizziness. Removed some furniture from bedroom to accommodate the Hoyer lift [full body lift], use Hoyer lift for transfer and made comfortable in bed. Pain pill was given an hr. [hour] before the fall. [The progress note did not identify the incorrect administration of Morphine Sulfate given mistakenly approximately an hour prior. See F 333]. Started on neuro (neurological) check per protocol. Dr. [Name] was notified about resident status and about BP (blood pressure) that is unable to obtain. 2230 [10:30 p.m.] BP 64/45. Advised to forced [sic] fluid intake and watch on [sic] any abnormal vitals. Resident is alert, speech clear and strength equal to bilateral hands. No SOB [shortness of breath] and refused ice pack for back of her head. . . Family will be notified in the morning. Monitor." * 12/01/2015 11:08 AM - "Family, res. [resident] daughter [name of daughter], was updated on fall and res condition. During an interview on 02/23/16 at 1:45 p.m. an administrative nurse (#1) stated, on 11/30/15 at 8:30 p.m. a medication nurse identified a medication error had occurred. The nurse, at that	F 157		

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F 157	Continued From page 4	F 157		

time, obtained Resident #8's vital signs which included a blood pressure of 114/55, heart rate 89 and respirations 20. At 9:16 p.m. Resident #8 sustained a fall and stated she hit her head. A health care practitioner (HCP) was not notified until 10:00 p.m. regarding the medication error and fall.

The facility failed to notify the HCP of the medication error until after the fall, and notify the family of the resident's significant change in status including the medication error and fall until the next day.

- Review of Resident #10's medical record occurred on February 23-24, 2016. Diagnoses included hypertension.

A nursing progress note stated the following: 05/05/2015 6:39 p.m. "Resident was ambulating with walker per self into dining area, while trying to sit down in dining room chair slid to floor hitting forehead on floor causing a skin tear to forehead and bridge of nose and redness noted to left shoulder. Resident was laying on left side with face down. Residents in dining room witnessed fall. Rotated Resident to back with pillow under head, ROM good of all extremities. States forehead hurts and feeling nausea [sic]. Small emesis observed. Hoyer lifted Resident to wheelchair. Vitals taken: [temp] 97.6, [heart rate] 75, [respiration] 21, [blood pressure] 73/48. Cleansed forehead and nose with NS [normal saline] and applied steri-strips to forehead. Neuro checks per protocol. Resident refused supper and wanted to go back to room and requested her daughter Sandy be called to come up. . . ."

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F 157	Continued From page 5 Resident #10's medical record lacked documentation that staff notified a HCP of the resident's fall, low blood pressure, and nausea.	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 164	1.The facility has identified that all	3/21/16

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F 164	Continued From page 6 facility failed to maintain the privacy and confidentiality of the resident's electronic Medication Administration Record (eMAR) and personal information on 2 of 4 units (Hope Avenue and Faith Lane) during medication pass and personal information of previous survey results posted during 3 of 4 days of survey. Failure to maintain confidentiality of residents' eMAR and personal information is an infringement of the residents' rights. Findings include: - Observation on the morning of 02/23/16 showed a licensed nurse (#3) left the medication cart (on Hope Avenue unit) with Resident #16's eMAR open and visible to other residents/staff members walking by the medication cart on two occasions. On a third occasion the nurse left the unit with the Resident #16's eMAR opened and did not return to the medication cart until three minutes later. - Observation on 02/23/16 at 8:14 a.m. showed an unattended medication cart located in Faith Lane lounge area with a paper facing right side up which contained personal resident information. Observation showed the licensed nurse (#2) administering medication to a random resident in the Faith Lane dining room. - Observation on 2/23/16 at 9:30 a.m. showed a licensed nurse (#2) at the far side of the Faith Lane dining room while Resident #19's eMAR remained open and visible to other residents/staff members walking by the medication cart. The licensed nurse (#2) did not have the medication cart within full view while administering	F 164	residents could be affected by the deficient practice. The facility will keep all resident information covered and private to prevent this occurrence in the future. 2.The facility has identified that all residents have private information within the facility being used by the staff. 3.The facility has corrected the deficient practice by removing the resident roster immediately when identified by survey team on 2/23/16. The information displayed in public areas will be doubled checked by receptionist to not include any information with resident□s names on it before posting. The personal information on the medication carts will be turned over or covered when staff leaves the med cart and the privacy screen turned on. Administration of Medication policy was update and reviewed (see attach #8). Education was given on 3/16/16. (attach #10) 4.The deficient practice was corrected on 3/16/16. 5.The Director of Nursing or designee will conduct random audit observations weekly X 4, monthly X 3, then quarterly X 3 to assure personal information on medication carts are covered and privacy screens are activated.	

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F 164	Continued From page 7 medication to Resident #19 across the dining room. During an interview on 02/24/16 at 10:15 a.m., an administrative nurse (#1) confirmed staff should not leave the eMAR's open, and personal information sheets should be turned faced down. - Observation on the afternoon of 02/23/16 showed the confidential resident roster information was included with the posting of the Health survey completed 01/22/15. The procedure for the facility is to post the previous years survey results to allow residents and visitors access to the report, but not to include the resident roster. During an interview on the afternoon of 02/23/16, an administrative staff member (#5) agreed the resident roster should not be posted with the survey results.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility staff failed to administer medications for 1 of 1 sampled resident (Resident #11) determined able to self-administer medications with assistance (SAMA). Failure of staff to ensure medications	F 176	1.Resident #11 was reassessed for SAMA and continues to be appropriate for Self -Administration of Medication. 2.The facility has determined that all residents choosing to self-administer medication with assistance have the	3/21/16

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F 176	Continued From page 8 are delivered directly to residents has the potential to result in a medication errors and/or harm to residents. Findings include: Review of the facility policy titled "Self Administration of Medication with Assistance (SAMA)" occurred on 02/24/16. This policy, revised 01/18/15, stated, ". . . 4. If found to be qualified for self-administration with assistance, the nurse will set up all scheduled medication and give them to the resident to take. . . ." Review of Resident #11's medical record occurred on February 23-24, 2016. The SAMA assessment showed Resident #11 qualified for self-administration with assistance. Observation on 02/22/16 at 11:02 a.m. showed a licensed nurse (#4) with medication for Resident #11 knocked on the resident's open room door. Resident #11's husband was seen sitting in the room. The licensed nurse (#4) asked the resident's husband where Resident #11 was. The husband's response was not clearly heard. Observation showed Resident #11 was not in the room. The licensed nurse (#4) then entered into Resident #11's room and placed a medication cup containing medications on the bedside table and left the room. The licensed nurse (#11) failed to deliver the medications directly to the resident.	F 176	potential to be affected by the deficient practice. 3.The facility updated the Self Administration of Medication with Assistance (SAMA) policy (attachment #6) on 3/1/16 (attachment #9) to include in #5 If found to be qualified for self-administration with assistance, the nurse will set up all scheduled medication and give them to the resident to take. Medications must be delivered directly to the resident. Education was provided on 3/1/16. 4.The facility corrected the deficiencies on 3/1/16. 5.The Director of Nursing or designee will monitor the facilities performance by observing administration of medication for resident□s who choose to self-administer medication with assistance. This will be completed on 4 SAMA residents weekly X 4, monthly X 3, and quarterly X 3, then reevaluate for further monitoring or interventions.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		3/21/16

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F 241	Continued From page 9 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner that enhanced dignity/self-esteem for 1 of 3 supplemental residents (Resident #19) observed during administration of insulin in the dining room. Failure to ensure dignity and respect during administration of insulin does not the recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: During interview on the morning of 02/21/16, the facility serves the breakfast meal between 07:10 a.m. and 9:45 a.m. Observation on 02/23/16 at 9:30 a.m. showed Resident #19 seated at the dining room table eating a bowl of cold cereal. A licensed nurse (#2) approached Resident #19 at the table and requested they move to the lounge to administer the resident's insulin. Resident #19 refused to leave and stated to do administer the insulin at the dining room table. As the resident ate his cereal, the nurse (#2) pulled Resident #19's chair away from the table and administered Resident #19's insulin. Several residents were seated nearby in the dining room and lounge area within view of Resident #19. During an interview on the morning of 02/24/16, an administrative nurse (#1) stated staff should not take the residents from the dining room table	F 241	1. Resident #19 had no negative outcome as a result of the deficient practice. 2. The facility identified that all residents residing in the facility have the potential to be affected by the same deficient practice. 3. The facility has corrected the deficient practice by educating the nurses on 3/1/16 (attachment #9)on their responsibility in ensuring the dignity/self-esteem by administering insulin in a private area. A Promoting/Maintaining Resident Dignity and Respect Policy (attachment #7) was also developed on 3/15/16. The facility also updated the Administration of Medication Policy (attachment #8)on 3/15/16. Nurses were reeducated on 3/16/16 (attachment #10)and Certified Nursing Assistants on 3/17/15 (attachment #11) regarding the new policy and the importance of maintaining resident dignity and respect. All staff are educated yearly on Resident□s Rights. 4. The facility corrected deficiency on 3/17/16. 5. The Director of Nursing or her designee(s) will complete random audit observations on insulin administration and other dignity related issues weekly X 4, monthly X 3, and quarterly X 3, then reevaluate for further monitoring or	

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F 241	Continued From page 10 during meals to administer medications.	F 241	interventions.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: PRIMING INSULIN PENS 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 3 of 3 supplemental residents (Resident #18, #19, and #21) observed during insulin administration. Failure to correctly prime an insulin pen has the potential for residents to receive an incorrect dose of insulin. Findings include: Review of the facility policy titled "Insulin Pen Administration" occurred on 02/24/16. This policy, dated 09/03/14, stated, ". . . Purpose: to provide appropriate insulin to appropriate resident . . . 3. Check the insulin pen for appropriate type of insulin and resident. 4. Take the cap off and look at the insulin reservoir to make sure insulin is clear. . . . 8. Select dose of 2 units by turning knob. 9. Take off inner needle cap and discard. 10. Prime the insulin needle with 2 units of insulin. . . ." - Observation on 02/22/16 at 9:35 a.m. showed a licensed nurse (#4) dialed Resident #18's Lantus insulin pen to 2 units, held the pen upward, and	F 281	1. Corrective action for resident□s #18, 19, and 21 was that education was provided to nurses on 3/1/16 and 3/16/16 on appropriate priming of insulin pen. Corrective action for resident #□s 16, 18, 19, and 20 was education provided to nurses and CMAs on the updated Administration of Medication Policy and proper procedure on signing off EMAR. Corrective action for residents #18 and #19 was education provided to nurses and CMAs on Medication Storage Policy. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. 3. The deficient practice will be corrected by reeducating Nurses and CMAs on the Insulin Pen Administration (attachment #12), Administration of Medications (attachment #8), and Medication Storage Policies (attachment #13). Education was provided on 3/1/16 and 3/16/16 (attachment #9 and #10). 4. The facility corrected deficiencies on 3/16/16. 5. The Director of Nursing or designee(s) will conduct QAs on medication administration, administration of insulin	3/21/16

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F 281	Continued From page 11 performed the airshot with the cap left on. The nurse failed to remove the cap before she performed the airshot to view the insulin and to verify the absence of air bubbles. - Observation on 02/22/16 at 10:24 a.m. showed a licensed nurse (#4) dialed Resident #21's NovoLog insulin pen to 2 units, held the pen upward, and performed the airshot with the cap left on. The nurse failed to remove the cap before she performed the airshot to view the insulin and to verify the absence of air bubbles. - Observation on 02/23/16 at 9:30 a.m. showed a licensed nurse (#2) dialed Resident #19's Humalog insulin pen to 2 units, held the pen in a horizontal position, and performed the airshot with the cap left on. The nurse failed to remove the cap and perform the airshot while holding the pen in an upright position. During an interview on the morning of 02/24/16, an administrative nurse (#1) confirmed the insulin pen caps should be removed and the insulin pen should be in an upright position when priming insulin pens. MEDICATION ADMINISTRATION 2. Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 4 of 4 supplemental residents (Resident #16, #18, #19, and #20) during medication administration. Failure to stay with a resident during medication administration and practice safe preparation and	F 281	pens, and medication storage on 3 nurses per week X 4, monthly X 3, then quarterly X 3 then reevaluate for further monitoring or interventions.	

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hygiene of medications does not ensure the safety of the resident or of the other residents who may take the medications.

Findings include:

Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 870-871, stated, ". . . Stay with the client until all medications have been swallowed. Rational: The nurse must see the client swallow the medication before the drug administration can be recorded . . ."

Review of the facility policy titled "Medication Storage" occurred on 02/24/16. This policy, revised on 09/07/14, stated, ". . . Medications and biologicals are stored safely, securely and properly . . . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. . . ."

Review of the facility policy titled, "Administration of Medications" occurred on 02/24/16. This policy, revised 10/11/15, stated, ". . . 7. Medications may not be set up in advance . . ."

- Observation on 02/22/16 at 8:39 a.m. showed Resident #20 seated at the dining room table for breakfast with a random resident seated next to her. Medications in a cup were observed on the table in front of the resident while the licensed nurse (#4) was administering medications to other residents.

During an interview on 02/24/16 at 12:10 p.m. an

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administrative nurse (#1) confirmed Resident #20 could not safely self administer medications.

- Observation on 02/22/16 at 9:34 a.m. showed a licensed nurse (#4) in the Grace Court kitchenette with her back turned toward the medication cart which is located in the Grace Court lounge. Two unlabeled cups of medications sat on top of the unattended medication cart. The nurse returned to the medication cart and administered the medications to Resident #18.

- Observation on 02/23/16 at 8:00 a.m. showed a licensed nurse (#3) prepared medications for Resident #16, signed off the medication in the electronic medication administration record, placed the medication cup with the medications on the dining room table in front of the resident, and then immediately returned to the medication cart to prepare additional medications.

Review of Resident #16's medical record occurred on the afternoon of 02/23/16. A self administration medication assessment (SAMA), dated 05/26/15, identified Resident #16 could not safely self administer medications.

- Observation on 02/23/16 at 9:30 a.m. showed a licensed nurse (#2) prepared Resident #19's medications. The nurse ejected the pills directly into her ungloved hands, placed the pills into a medication cup, and administered the medication to Resident #19. The nurse failed to use proper hygiene when handling medications.

During an interview on the morning of 02/24/16, an administrative nurse (#1) confirmed staff should eject the medication pills directly from the

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F 281	Continued From page 14 package into a medication cup. UNLOCKED MEDICATION CART 3. Based on observation and review of facility policy, the facility failed to ensure medications were stored securely on 1 of 4 units (Faith Lane). Failure to lock the medication cart when unattended could result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medication Storage" occurred on 02/24/16. This policy, revised on 09/07/14, stated, ". . . Medications and biologicals are stored safely, securely and properly . . . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Observation on 02/23/16 at 8:14 a.m. showed an unlocked medication cart located in the Faith Lane lounge. A licensed nurse (#2) was observed in the Faith Lane dining room administering medications to a random resident seated at a table located across the room. Observation on 02/23/16 at 9:30 a.m. showed a licensed nurse (#2) prepared medications for Resident #19 in the Faith Lane lounge. The nurse then walked into the Faith Lane dining room to administer oral medications and insulin to Resident #19, leaving the unlocked medication cart in the Faith Lane lounge unattended. The staff's failure to secure the medication cart	F 281		

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F 281	Continued From page 15 prior to leaving the area may have resulted in unauthorized access to the medications stored in the cart.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide adequate supervision and necessary assistive devices during transfers for 1 of 6 sampled residents (Resident #11) observed during transfers. Failure of staff to provide adequate supervision and utilize a gait belt to prevent accidents has the potential to result in resident falls and/or injuries. Findings include: Review of the facility policy titled "Transfers with use of Transfer Belts/Mechanical Lifts" occurred on 02/24/16. This policy, revised 04/09/15, stated, ". . . If a resident needs hands on assistance of trained staff for balance or lifting and maintaining standard position, transfer belt/gait belt must be used, unless otherwise care planned. . . ."	F 323	1. Resident #11□s transfer method was reassessed by Physical Therapy on 3/2/16 (attachment #14) and anti-rollbacks were placed to her wheelchair on 3/2/16. Resident #11 was also educated by Physical Therapy on use of the transfer belt for the safety of the staff and herself. 2. The facility has determined that all residents requiring assistance have the potential to be affected by this deficient practice. 3. The facility will correct the deficient practice by reeducating staff on the Transfer Policy (attachment #15) and the need for reassessment if resident□s abilities in transferring safely, change. This was completed for nurses on 3/16/16 (attachment #10) and CNAs on 3/17/16 (attachment #11). 4. The facility corrected the deficiency on	3/21/16

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F 323	Continued From page 16 Review of Resident #11's medical record occurred on February 23-24, 2016. The annual Minimum Data Set (MDS), dated 01/09/16, identified extensive assistance of one person for transfers and locomotion on unit. Resident #11's current care plan stated, ". . . Problem Onset: . . . requires staff assistance with ADL's [activities of daily living] [at] times . . . Approaches . . . Transfer independently with FWW [front wheel walker] on day shift. Transfers with one assist and FWW on PM [night] . . . Give [name of resident] verbal cues to help prompt . . . Assist with ADLs as needed . . . Problem Onset: . . . has an increased risk for falls r/t [related to] Parkinson's, psychotropic med use, muscle weakness, abnormal gait, lack of coordination . . ." Review of Resident #11's transfer assessment occurred on 02/24/16. The assessment, dated 01/06/16, stated, ". . . Recommend Transfer Method . . . Independent . . . Transfer one with gait belt . . . Mobility Aid Utilized . . . Front Wheeled Walker . . ." Observation on the morning of 02/21/16 showed Resident #11 self ambulating in the dining room utilizing her wheelchair as a walker. Resident #11 stood behind her wheelchair and pushed the wheelchair to the dining room table. The resident walked to the front of the unlocked wheelchair and fell back into the wheelchair seat as the wheelchair rolled backwards away from the dining room table. Several random staff members in the dining room watched Resident #11 self transfer. The staff members failed to offer assistance with her transfer, utilize a gait belt, and encourage the use of a FWW.	F 323	3/17/16. 5. The Director of Nursing or Designee(s) will conduct a QA on 4 residents to assure reasidents are being safely transferred according to their recommended transfer method weekly X 4, monthly X 3, and quarterly X 3, then reevaluate for further monitoring or interventions.	

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F 323	Continued From page 17 Observation on 02/23/16 at 2:33 p.m. showed a certified nurse assistant (CNA) (#8) transfer Resident #11 from the wheelchair to the recliner. The CNA (#8) moved the wheelchair to face the recliner, locked the wheelchair, and encouraged the resident to stand and pivot herself into the recliner. Resident #11 was unable to pull herself up to stand and pivot. The CNA (#8) used both of her hands under Resident #11's buttocks to help push her up to standing position. The resident then twisted herself and fell back into the recliner to sit. The CNA (#8) failed to utilize a gait belt and provide appropriate assistance during the transfer. Observation on 02/23/16 at 3:06 p.m. showed a CNA (#8) transferred Resident #11 from her wheelchair to the toilet. The CNA (#8) placed the resident in front of the toilet and locked the wheelchair in place. Resident #11 utilized both wall rails beside the toilet to pull herself up. The resident, unable to fully stand, twisted herself around, and fell back landing on half of the toilet seat. The CNA (#8) failed to utilize a gait belt and provide appropriate assistance during the transfer. During an interview on the morning of 02/24/16, an administrative nurse (#1) stated she was not aware of the updated transfer recommendations to Resident #11's transfer assessment on 01/06/16. The facility staff failed to utilize a gait belt and provide adequate supervision and assistance during Resident #11's transfers and self ambulation.	F 323		

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F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/22/15. Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #4) with orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels and failure to consistently monitor/document saturations 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," 9th ed., Pearson Education, Inc,	F 328	1.Resident #4□s oxygen saturations were monitored and it was determined that resident□s oxygen saturations were maintained above 90% on room air during the day, however did drop when resident was lying in bed sleeping. Orders were changed to indicate oxygen to be used PRN during the day and to be on continuous at night. 2.The facility has determined that all residents with orders for continuous oxygen use have the potential to be affected by this deficient practice. 3.The orders for all residents currently receiving continuous oxygen therapy were reviewed and changed as needed. The facility has implemented orders into the Electronic Treatment Record (ETAR) (attachment #16)for all residents on oxygen therapy which will require a licensed nurse to provide daily	3/21/16

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F 328	Continued From page 19 New Jersey, page 1397, stated, "OXYGEN THERAPY . . . 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. Excessive amounts of oxygen can lead to pulmonary oxygen toxicity . . ." Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included chronic obstructive pulmonary disease and dementia. Resident #4's current care plan stated, ". . . Problem Onset: . . . has COPD [chronic obstructive pulmonary disease] and I get SOB [shortness of breath]. . . . Approaches . . . OXYGEN ON AT 1-4L/NC [liter/nasal cannula] CONTINUOUSLY TO KEEP SATS [saturations] above 90% . . ." The physician orders stated ". . . OXYGEN ON AT 1-4L/NC CONTINUOUSLY TO KEEP SATS ABOVE 90% . . ." Review of Resident #4's oxygen saturation record showed staff documented the resident's oxygen saturation on the following dates and did not indicate what percentage of oxygen delivered: * 08/19/15 at 9:23 a.m. * 08/24/15 at 6:39 p.m. * 09/11/15 at 12:58 p.m. * 10/14/15 at 1:27 p.m. * 11/18/15 at 10:15 a.m. * 11/23/15 at 1:14 p.m. * 11/23/15 at 2:46 p.m. * 12/30/15 at 1:30 p.m. * 01/07/16 at 10:42 a.m.	F 328	documentation on the resident□s oxygen saturation when at rest or upon exertion. A licensed nurse will also be required to provide ETAR documentation on the liter flow being used as well as if oxygen is on/off. Nurses were educated on 3/16/16 (attachment #10)on the new orders in the ETAR for oxygen therapy and the need to assess oxygen saturation and liter flow for proper oxygen therapy use. They were also educated on the Oxygen Policy (attachment #17)which was reviewed and updated on 3/15/16. Certified Nursing Assistants were educated on 3/17/16 (attachment #11)to notify the nurse when residents display signs of hypoxia such as shortness of breath and confusion. They were also reeducated on following care guides which indicate the resident□s need for continuous or as needed oxygen therapy. 4.The facility corrected deficiencies as of 3/17/16. 5.The Director of Nursing or designee will conduct a QA on completing observations on all resident□s requiring continuous oxygen receive continuous therapy during cares. This will be conducted weekly X 4, monthly X 3, and quarterly X 3, then reevaluated for further monitoring and interventions. A QA will also be developed to ensure accurate documentation and physician notification on oxygen saturations which will be done weekly X 4, monthly X 3, and quarterly X 3 then reevaluated for further monitoring and interventions.	

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F 328	Continued From page 20 * 01/22/16 at 10:06 a.m. * 01/22/16 at 3:36 p.m. * 02/09/16 at 11:14 a.m. * 02/17/16 at 10:40 a.m. * 02/18/16 at 10:37 a.m. * 02/22/16 at 8:34 a.m. * 02/23/16 at 10:35 a.m. * 02/23/16 at 3:47 p.m. The facility failed to monitor and document Resident #4's oxygen saturation consistently to assess and determine the necessity and amount of oxygen liters needed. Observation on 02/21/16 at 10:23 a.m. showed Resident #4 in his bed with his nasal cannula lying on the bed next to his legs and the oxygen concentrator set at 4 liters. Observation on 02/22/16 at 9:45 a.m. showed Resident #4 in bed with his nasal cannula down around his chin. The certified nurse assistant (CNA) (#6) assisted the resident into his wheelchair. The resident removed his nasal cannula, threw it on his bed, and self propelled himself into the bathroom. The CNA (#6) followed Resident #4 into the bathroom to assist with his daily cares. At 10:15 a.m. the resident reported shortness of breath to the CNA (#6). The CNA (#6) told Resident #4 to put on his oxygen (via nasal cannula) present on the backside of the wheelchair. The CNA (#6) set the oxygen to 4 liters and assisted the resident into his wheelchair. The resident self propelled to the bedside. The CNA (#6) failed to provide continuous oxygen as ordered during cares and failed to inform the nurse so an assessment of the resident's complaint of shortness of breath could be completed to determine the amount of	F 328		

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F 328	Continued From page 21 oxygen needed. Observation on 02/22/16 at 3:06 p.m. showed Resident #4 in his bed. The CNA (#7) assisted the resident into his wheelchair. The resident self propelled into the bathroom without oxygen. The CNA (#7) assisted the resident with toileting cares, hand washing, and then assisted the resident back into his wheelchair. At 3:13 p.m. Resident #4 self propelled to his bedside. Resident #4 applied his own oxygen nasal cannula set at 4 liters. The CNA (#7) failed to encourage the use of oxygen continuously during cares. During an interview on the morning of 02/24/16, an administrative nurse (#1) confirmed facility staff failed to consistently monitor Resident #4's saturation levels. The nurse (#1) also stated she expected staff to provide the resident with oxygen during cares. The facility failed to provide continuous oxygen as ordered, consistently monitor and document the resident's oxygen saturation, and assess the resident to determine the amount of oxygen liters needed.	F 328		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that 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	F 333	1.The nurse responsible was educated on proper medication administration and	3/24/16

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F 333	Continued From page 22 residents remained free from significant medication errors for 2 of 2 sampled residents (Resident #8 and #12) identified affected adversely by a medication error. Failure to ensure residents received the correct medications resulted in Resident #8's experiencing a fall with an injury, a severe drop in blood pressure, and a temporary decline in mental and physical status, and had the potential for Resident #12 to experience avoidable discomfort. Findings included: Review of the facility policy titled "Medication Error" occurred on 02/23/16. This policy, dated 09/07/14, stated, "Medication error: . . . Significant medication error caused [sic] the resident discomfort or jeopardizes his or her health and safety. Examples are: 1. Omissions 2. Unauthorized drugs (drugs administered without a physician's order). . . Any medication error must be reported to the resident's attending physician, A medication Error Form completed and the DON [Director of Nursing] notified. . . . Procedure 1. . . . If the error or errors is significant, notify the DON ASAP [as soon as possible]. . . .3. Depending on the severity of the error, the medications the resident should have received may be held until the physician is updated. . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included diabetes and hypertension (high blood pressure). Medications included Coumadin (blood thinner) 2 mg (milligrams) daily, Tramadol (pain medication) 50 mg two times a day, Tylenol	F 333	appropriate notification of family and physician for resident #8.Resident #8 and #12's medical records were updated to include the event that occurred on 11/30/15. 2.The facility has determined that all residents residing in the facility have the potential to be affected by this deficient practice. 3. The facility has corrected the deficiency by reviewing the Notification of Change Policy (attachment #1). The facility also reviewed and updated the Medication Error Policy (attachment #3)and Incident and Accident Policy (attachment #18). Education was provided to the nurses on 3/16/16 (attachment #10) of the reviewed and updated policies as well as education provided on how to complete accurate documentation (see attachment #21). Nurses were also educated on a video titled "8 Rights of Medication Administration" by Lippincott Nursing Center. 4. The facility has corrected this deficiency as of 3/16/16. 5. The Director of Nursing or designee(s) will conduct a QA on medication administration on three nurses weekly X 3, monthly X 3, and quarterly X 3, then reevaluate for further monitoring and interventions.	

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F 333	Continued From page 23 Ex-Str (extra strength) 1000 mg and metoprolol (to lower blood pressure) 50 mg two times a day. During an interview on 02/22/16 at 5:02 p.m. an administrative nurse (#1) stated before Resident #8 sustained a fall on 11/30/15 a medication error occurred. The medical record lacked documentation of the medication error. (Refer to F514) During an interview on 02/23/15 at 08:15 a.m. an administrative nurse (#1) stated on 11/30/15 at approximately 8:00 p.m. Resident #8 received Resident #12's medications. The medications orally administered to Resident #8 included: * Trazadone (antidepressant) 300 mg, * MS ER (morphine sulfate-extended release narcotic pain medication) 30 mg * Senna (laxative) 3 tablets The administrative nurse (#1) also stated at 9:16 p.m. Resident #8 sustained a fall. A nursing staff member on duty informed this administrative nurse (#1) at 9:30 p.m. of the medication error and the fall. The nursing staff member failed to notify the DON of the medication error ASAP. Neurocheck Assessment worksheets identified the following on 11/30/15: * 9:30 p.m. blood pressure (B/P) 114/55 - Pulse (P) 89 - Respirations (R) 20 - "Comments: Complain of dizziness, #6 pain [pain scale of 1-10] back of her head and lower back pain." * 9:45 p.m. B/P 77/47 - P 80 - R 18 * 10:00 p.m. B/P unable to obtain - P 61 - R 20 - Comments: ". . . BP unreadable, [local hospital] notified [name of nurse practitioner] [NP] aware. . . . Still c/o [complain of] #6 dizziness and lower back and back of head pain, Offered Ice pack,	F 333		

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	355041	A. BUILDING _____ B. WING _____	02/24/2016

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resident refused stating 'It will go away.'" The medical record lacked orders/instructions received from the NP. The staff notified the NP approximately two hours after the nurse discovered the medication error.
* 10:15 p.m. B/P unable to obtain - P 82 - R 20 - Comments: " . . . B/P 64/45 Notified [name of NP], she said to continue monitor Vitals and call [local hospital] if any unusual results."
* 10:30 p.m. B/P 64/45 - P 83 - R 20 - Comments: ". . . Able to get B/P reading of 64/45, [name of NP] notified and suggested to forced [sic] fluids [sic] intake." The record lacked evidence of a telephone order.
* 11:00 p.m. B/P unable to obtain - P 86 - R 20 - Comments: ". . . unable to get BP reading, started on water orally."
* 11:30 p.m. B/P unable to obtain- P 79 - R 20 - Comments: " . . . denies pain and started on 7-up." Staff failed to notify the NP of "any unusual results" in vitals for two hours (10:30 p.m. to 12:30 a.m.).

Neurocheck Assessment worksheets identified nursing staff did not ensure the stability of Resident #8's blood pressure to ensure normal readings for a period of six hours on 12/01/15:
* 12:30 a.m. B/P 105/70 - P 59 - R 26 - Comments: " . . . notified (name of NP) stated to continue oral fluids . . ."
* 1:30 a.m. B/P unable to obtain P 79 R 16 Comments: " . . . No BP reading, gave another can of diet 7-up. Denies pain"
* 2:30 a.m. B/P 76/45 - P 74 - R 18
* 3:30 a.m. B/P 72/44 - P 79 - R 20
* 7 :30 a.m. B/P 110/60 - P 60 - R 20

Nursing progress note stated the following:

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F 333	Continued From page 25 * 12/1/2015 1:58 AM - (On 11/30/15 at 9:15 p.m.) - "CNA [certified nursing assistant] was calling this nurse over handset to go to resident room. Observed resident in supine position and stated that she got up and was about to lower her window blinds when she felt dizzy and lost her balance, she added she hit the back of her head. Room is crowded with furniture and resident has gripper socks on. No swelling or redness back of her head [sic], ROM [range of motion] ok, upper and lower extremities has no pain upon moving and equal in length. Voiced #6 pain to back of head and lower back pain and with some dizziness. Removed some furniture from bedroom to accommodate the Hoyer lift [full body lift], use Hoyer lift for transfer and made comfortable in bed. Pain pill was given an hr. [hour] before the fall. Started on neuro (neurological) check per protocol. Dr. [Name] was notified about resident status and about BP (blood pressure) that is unable to obtain. 2230 [10:30 p.m.] BP 64/45. Advised to forced [sic] fluid intake and watch on [sic] any abnormal vitals. Resident is alert, speech clear and strength equal to bilateral hands. No SOB [shortness of breath] and refused ice pack for back of her head. . . Family will be notified in the morning. Monitor." * 12/1/15 9:52 a.m. ". . . lethargy. Res. [Resident] was very tired this am [a.m.] and was not going to eat BF [breakfast] so did hold insulin." * 12/1/2015 at 11:00 a.m. "Res very lethargic. She does respond, but is very slow to respond. Her speech is slurred. Pupils are pinpoint and very sluggish. Hand grasps are equal and strong bilat. [bilateral]. 'I'm just so tired..' Dr. [name] made aware of the above. Orders received to get CT [cat scan] of head."	F 333		

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F 333	Continued From page 26 * 12/1/2015 4:19 p.m. "Denies pain . . . Res. alert but still sleepy and able to answer questions." * 12/1/2015 10:19 p.m. "Resident still very lethargic and confused about the date. . . . BS [blood sugar] 179, and went right back to sleep. . . ." * 12/2/2015 1:41 a.m. "Resident alert, tired and feels 'shot [sic] circuited' but no confusion now. . . ." * 12/2/2015 2:57 p.m. "Res is still very sleepy today. . . ." * 12/02/2015 10:15 p.m. "Resident remains very lethargic. . . . Has difficulty getting up but stands well and holds on to bars well in BR [bathroom]. Once back in bed, sleeps immediately." * 12/3/2015 9:43 a.m. "Resident is alert and oriented. . . . Still c/o [complain of] mild pain to top of head from fall. . . . Very tired. Had breakfast tray in room and is back in bed resting. . . ." The November 2015 medication administration record identified Resident #8 received her 8:00 p.m. medications as scheduled on 11/30/15 which included the metoprolol 50 milligrams (mg), Tramadol 50 mg, Coumadin 2 mg, Lantus insulin 40 units subcutaneously, and Tylenol Extra Strength. A physician progress note, dated 12/03/15 stated, " The patient is in for recertification. Apparently fell and bumped her head. She had CTs [cat scan] of the C- [cervical] spine and brain yesterday that were basically normal. . . . Mild concussion. . . ." Resident #8 received Resident #12's medications which resulted in a fall sustaining a mild	F 333		

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F 333	Continued From page 27 concussion, an unstable condition noted by low blood pressure readings, and lethargy for approximately three days. In addition, staff failed to: * notify the NP until approximately two hours after the medication error occurred. * notify the NP when unable to obtain a BP reading for two hours * monitor blood pressures to ensure normal readings for a period of six hours on 12/01/15. * document telephone order regarding orders received. * ensure documentation of the event in the medical record to ensure proper follow-up monitoring/communication. - Review of Resident #12's medical record occurred on 02/24/16. Record review identified the resident received scheduled Morphine Sulfate (pain medication) two times a day for chronic pain, and Trazadone (antidepressant) on a daily basis for insomnia. On the evening of 11/30/15 nursing staff failed to ensure Resident #12 received these two medications after an event with another resident. Failure to administer Resident #12's scheduled medications could adversely affect this resident's pain level and ability to rest.	F 333		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		3/23/16

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F 356	Continued From page 28 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post their nurse staffing information for 3 of 6 units (Angel Road, Faith Lane and Grace Court) in a place which was easily visible/available for the residents and the public. Findings included: Observation on the morning of 02/24/16 showed the nurse staffing information posted in the business district corridor, a corridor lined with the	F 356	1.No corrective action is needed as there were no residents affected by the deficient practice. 2.The facility has determined that all residents have the potential to be affected by this deficient practice. 3.The posted nurse staff information was moved to the public information board by the front entrance which is easily visible and available for resident and public viewing. Education was provided in the nurses meeting on 3/16/16 by scheduler.	

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F 356	Continued From page 29 offices of several managerial staff. The corridor led to the Joy, Hope and Peace resident units, however, visitors accessing the other three nursing units, Angel Road, Faith Lane and Grace Court, would not pass through this corridor to access those units. On the morning of 02/24/16, a supervisory staff member (#1) stated the posting of staff is not in any other location within the facility. The facility failed to post the information in an area easily accessible to the residents and the public.	F 356	(attach #20) 4.The correction of the deficient practice occurred on 3/9/16. 5.The Director of Nursing or designee will conduct a QA weekly X 4, monthly X 3, then quarterly X 3 to assure that proper observation of expired medications are completed.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to store foods in a safe and sanitary manner in 1 of 1 dietary supply room. Failure to ensure food storage areas are free from storage of chemicals may result in chemical contamination of food. Findings include:	F 371	1.No corrective action needed as no residents were affected by the deficient practice. 2.The facility has identified that all residents in the facility have the potential to be affected by the deficient practice of chemicals being stored in the same room and food.	3/21/16

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F 371	Continued From page 30 Review of the facility policy titled "Proper food storage" occurred on 02/24/16. This policy, revised 10/01/14, stated, ". . . 7. No chemicals are to be stored in the dry storage room. . . ." Review of the facility policy titled "Chemical storage" occurred on 02/24/16. This policy, revised 10/01/14, stated, ". . . 2. All chemicals are to be stored away from all food items. . . . 3. Chemicals are stored in Dietary Managers office and or gray cabinet in kitchen for everyday use chemicals ex: dish soap, bleach. . . ." Observation on 02/21/16 at 10:02 a.m. of the dietary supply room showed approximately twenty cases of carbonated beverages for resident use in open and closed boxes. Numerous bottles, boxes, and cans of chemicals (eco lab ultra klen, 409 bottles, super trump multi purpose cleaner, cascade dishwashing detergent, Clorox bleach, and spray cans of stainless steel cleaner) were observed in the same storage room as the soda cases. The facility failed to keep the storage of chemicals separate from the storage beverages designated for resident consumption.	F 371	3.The facility moved all chemicals to a locked storage room. Education was given to dietary staff on 3/12/16 about the storage of chemicals and food in the same room. 4.The facility corrected the deficiency as of 3/14/16. 5.The Dietary manager or designee will monitor weekly X 4, monthly X 3, then quarterly X 3 to assure that substantial compliance is maintained.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		3/24/16

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F 514	Continued From page 31 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure 2 of 13 sampled residents (Resident #8 and #12) had a complete and accurate medical record. Failure to ensure a complete and accurate medical record does not allow staff and/or providers to have access to all information necessary to provide care and treatment for the residents. Findings include: Review of the facility policy titled "Incident and Accident" occurred on 02/23/16. This policy, dated 10/20/14, stated, ". . . Documentation: a. Incident/accident and interventions should be documented in the nurse's notes . . ." During an interview on 02/22/16 at 5:02 p.m., an administrative nurse (#1) stated before Resident #8 sustained a fall on 11/30/15 a medication error had occurred. The medical record lacked documentation regarding the medication error on 11/30/15 involving Resident #8 who sustained a fall with injury. (Refer to F333) - Review of Resident #12's medical record occurred on 02/24/16. Record review identified	F 514	1.Resident #8 and #12's medical record were updated to include the event that occurred on 11/30/15. 2. The facility has determined that all residents residing in the facility have the potential to be affected by the same deficient practice. 3. Nurses were educated on 3/1/16 (attachment #9) and 3/16/16 (attachment #10)on how to complete accurate documentation (see attachment #21. They were also reeducated on the Incident and Accident Policy on 3/16/16 (attachment #18). 4. The facility has corrected the deficiency as of 3/17/16. 5. The Director of Nursing or designee will conduct a QA on all residents□ nurse□s notes weekly X 4, monthly X 3,and quarterly X 3, then reevaluate for further monitoring or interventions.	

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F 514	Continued From page 32 the resident received his scheduled evening dose of Trazadone (an antidepressant) and Morphine Sulfate (pain medication) on the evening of 11/30/15. Review of #8's medical record occurred on all days of survey. Review of the record determined a nursing staff member administered the two medications listed above to Resident #8 on this evening. During interview on the morning of 02/24/16, an administrative staff member (#1) reported the nurse failed to administer the two above mentioned medications to Resident #12, and therefore, the record should have reflected that. The nurse who administrated the medication to the wrong resident (Resident #8) documented the medication also administered to Resident #12, when this did not occur.	F 514		