STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355034	A. BUILDING _____ B. WING _____	08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 08/08/21 and concluded 08/11/21.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents could safely self-administer medications for 1 of 1 sampled resident (Resident #26) and 1 supplemental resident (Resident #9) observed with medications in their rooms. Failure to obtain a physicians order for residents to self-administer medications (SAM) and evaluate/re-evaluate the resident's ability to safely self-administer medications may result in a medication error and/or harm to a resident. Findings include: Review of the policy titled "Self-Administration Medications & Treatments" occurred on 08/10/21. This policy, dated July 2006, stated, ". . . Self-administration of medications or treatments by residents is permitted by a physician's order that includes dosage, route, and any special instructions. . . . Self-administration of medications and treatments assessment is completed by RN/LPN [Registered Nurse/Licensed Practical Nurse]. Following	F 554	1. Resident #26 orders for Refresh eye drops obtained and entered on 8/10/21, order updated to may self-administer on 8/30/21. Self-administration assessment completed 8/30/21. Care plan updated for self-administration of eye drops. Resident #9 on 8/30/21 orders for vitamins changed to may self-administer. Self-administration assessment completed 8/30/21. Care plan updated for self-administration of medications. 2. All residents have the potential to be affected by the facilities failure to assess for self-administration of medications. 3. Staff were educated on not leaving medications at bedside and will be re-educated on same at mandatory all staff meeting. Staff will be educated on self-administration of medications policy and procedure at mandatory all staff meeting on 8/30/21. 4. QI monitoring will be done on 3 random residents to ensure that medications are not left at bedside. QI	8/30/21

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

Electronically Signed | 08/30/2021

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F 554	Continued From page 1 assessment, appropriateness of self-administration will be determined. . . . Procedure: . . . Obtain physician's order for self-administration of medication. Record on MAR [medication administration record] and resident care plan. . . Upon initiation of self-administration, medication nurse will assess self-administration and recording of medication/treatment weekly for one month, then quarterly and/or whenever there is a significant change in the resident's condition. . . ." - Observations on 08/09/21 at 10:14 a.m. and 08/10/21 at 7:55 a.m. showed a partial box of single use containers of Refresh eye drops on the overbed table in Resident #26's room. The resident reported self-administration of Refresh eye drops as needed and stated he/she had numerous sinus surgeries due to eye pressure, his/her eyes become very dry, scratchy, and sensitive to light. Observations on all days of survey showed Resident #26 wore sunglasses intermittently throughout the day. Review of Resident #26's medical record occurred all days of survey. The record lacked a physician's order for Refresh eye drops, a physician's order for SAM, an assessment for SAM, and an update to the resident's care plan. During an interview on 08/10/21 at 9:35 a.m., an administrative nurse (#2) confirmed the facility staff failed to obtain a physician's order for Refresh eye drops, complete a SAM assessment, and update the care plan for Resident #26. - Observation on 08/10/21 at 11:06 a.m. showed	F 554	will be completed by the DON/QI designee daily x 5, then weekly x 4, then monthly x 2 then quarterly x 2 unless determined otherwise by the QI committee at the monthly meeting. QI monitoring will be done on residents #26 and #9 and any new residents added to self-administration of medications, to ensure self-administration assessments are completed. QI will be completed by DON/QI designee weekly x 4, then quarterly x 2 unless determined otherwise by the QI committee at the monthly meeting. 5. 8/30/21	

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F 554	Continued From page 2 a plastic medication cup containing pills located on Resident #9's overbed table. Resident #9 identified the pills as vitamins, and stated, "They leave them for me so I can take them throughout the day." Review of Resident #9's medical record occurred on all days of survey. The record lacked a physician's order for SAM, an assessment for SAM, and an update to the resident's care plan.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		8/30/21

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F 578	Continued From page 3 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure the medical record for 1 of 14 sampled residents (Resident # 16) accurately reflected the resident's Advanced Directives regarding code status. Failure to document the resident's updated code status wishes limited the facility's ability to communicate to direct care staff and emergency personnel the resident's choice in the event of a medical emergency and may have resulted in unwanted treatment. Findings include: Review of the facility policy titled "Communication of Code Status" occurred on 08/11/21. This policy, updated June 2017, stated, "It is the policy of this facility to adhere to residents' rights to formulate advanced directives. . . . this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. . . . When an order	F 578	1. Resident #16 code level was updated in EMR on 8/9/21. 2. All residents have the potential to be affected by the facilities failure to ensure the medical record accurately reflects residents Advance Directives regarding to code status. 3. All current residents medical records will be reviewed to ensure correct code level is noted as per their wishes/AD. Code status will be address on admission and medical record will be reviewed with each MD rounds visit to any revisions/updates. Staff will be educated on accuracy of medical record regarding code status at mandatory all staff meeting on 8/30/21. 4. QI on resident #16 chart x 1 to ensure compliance. QI will be done on 3 random residents medical records to ensure code status is correct though-out record and EMR, weekly x 4, then monthly x 2 then	

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F 578	Continued From page 4 is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in [the] designated sections of the medical record. . . . The resident's code status will be reviewed at least quarterly and documented in the medical record." Review of Resident #16's medical record occurred on all days of survey. The resident's Electronic Medical Record [EMR] identified a physician's order, dated 06/01/12, Level One-Total Support. The EMR also showed Code Level 1 on the face sheet, CPR [cardiopulmonary resuscitation] beside the resident identification information at the top of the computer screen, and Code Level 3 (Limited Support, Excluding CPR) on the current care plan. Review of Resident #16's paper chart showed a form titled "PHYSICIANS DNR [Do Not Resuscitate] ORDER SHEET," signed and dated by the provider on 06/08/2020, indicated a Code Level 3. During an interview on 08/09/21 at 2:07 p.m., an administrative staff member (#2) reported the sheet located in the paper chart titled "PHYSICIANS DNR ORDER SHEET," dated 06/08/2020, as Resident #16's current physician's order and agreed the facility staff failed to update the EMR when the code status changed from a Level 1 to a Level 3.	F 578	quarterly x 2 unless determined otherwise by the QI committee at the monthly meeting. 5. 8/30/21	
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing	F 582		8/30/21

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F 582	Continued From page 5 facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or	F 582		

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F 582	Continued From page 6 discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to provide the Centers for Medicare/Medicaid Services (CMS) Notice of Medicare Provider Non-coverage (NOMNC) form (CMS-10123) and/or Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form (CMS-10055) to 2 of 2 residents (Resident A and #9) discharged from Medicare Part A services. Failure to provide the correct notices upon termination of Medicare Part A services, the updated contact information for the intermediary review agency, and ensure the residents received all available options to appeal the termination of coverage has the potential to hinder the residents' right to an expedited review of a service termination. Findings include: Review of the Medicare Part A letters/notices for Resident A and #9 occurred on the afternoon of 08/09/21. The records identified the following: * Resident A received the NOMNC form (CMS - 10123) and the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) on 04/11/21. The NOMNC form lacked the updated contact	F 582	1. The facility updated the NOMNC and SNFABN notices. Resident A is deceased. Resident #9 was given an updated notice x 2 with correct information 8/27/21. 2. All residents have the potential to be affected by the facilities failure to be provide forms NOMNC and SNFABN with accurate content regarding discharge from Medicare part A services. 3. NOMNC and SNFABN notices were updated with correct content. Staff will be re-educated on required notices and contact information at the mandatory all staff meeting on 8/30/21 4. QI monitoring will be done on each resident issued a Medicare denial form (NOMNC and SNFABN); the QI will be done prior to the form being issued to the resident/family to ensure the correct form and information is given. QI monitoring will be completed by the DON/QI designee weekly x 4, then monthly x 2, then quarterly x2 unless determined otherwise by the QI committee at the monthly meetings. 5. 8/30/21	

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F 582	Continued From page 7 information for the intermediary review agency and the SNFABN lacked all termination of coverage appeal options. * Resident #9 received the NOMNC form and the SNFABN on 08/04/21. The NOMNC form lacked the updated contact information for the intermediary review agency and the SNFABN lacked all termination of coverage appeal options. During an interview on 08/10/21 at 8:00 a.m., an administrative staff member (#2) confirmed staff utilized the incorrect NOMNC and SNFABN forms for Resident A and Resident #9 when discharged from Medicare Part A services.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 13 sampled residents (Resident #20). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual,	F 641	1. Resident #20 MDS was corrected 8/11/21. 2. All residents have the potential to be affected by the facilities failure to ensure accurate coding of the MDS. 3. All current residents MDS section K will be reviewed to ensure it is accurately coded. Staff will be educated on the accurately coding of the MDS at the mandatory all staff meeting on 8/30/21. 4. QI monitoring will be done on resident #20 section K of MDS quarterly x 1 year. QI will be done on 3 random residents section K of MDS weekly x 4, then monthly x 2, then quarterly x 2 unless	8/30/21

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F 641	Continued From page 8 revised October 2019, pages K-5-6 stated, ". . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available . . . Code 2, yes, not on physician prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days and the weight loss was not planned and prescribed by a physician . . ." Review of Resident #20's medical record occurred on all days of survey. The resident's current MDS, dated 07/23/21, showed a weight of 88 pounds (lbs.) and identified a weight loss. One 06/14/21, one month prior, the medical record identified a weight of 91.7 lbs., a 3.60 percent weight loss. During an interview on 08/10/21 at 3:18 p.m., a certified dietary manager (#1) confirmed staff incorrectly coded Resident #20's MDS for weight loss.	F 641	determined otherwise by the QI committee at the monthly meetings. 5. 8/30/21	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		8/30/21

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F 657	Continued From page 9 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, resident/resident representative, and staff interviews, the facility failed to ensure staff reviewed and revised comprehensive care plans to reflect the residents' current status for 6 of 13 sampled residents (Resident #3, #8, #11, #16, #20, #26) and 1 supplemental resident (Resident #9) reviewed. Failure to review and revise the care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy and procedure title "Multidisciplinary Care Plan" occurred on 08/10/21. This policy, dated August 2003, stated, "An interdisciplinary team . . . will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental	F 657	1. Residents #3 care plan was updated to anti-depressant, anti-anxiety, and opiod use, and current diagnosis of Multiple Sclerosis, Periperal Vascular Disease and Anxiety; as well as family noting to offer pills to help her headache if refusing medications. Resident #8 is discharged. Resident #9 care plan was updated to show self-administration of medications. Resident #11 care plan was updated to reflect problems of cancer, ICP, and foley catheter use as well as the use of anti-depressants, anti-seizure, and cancer medications. Resident #16 care plan was updated to reflect him changing his mind frequently about discharging from facility. Resident #20 care plan was updated to have a personalized goal for weight loss	

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F 657	Continued From page 10 and psychosocial needs that are identified in the comprehensive assessment. . . . Assessment and care plan evaluation must be ongoing. . . Monitor the resident's response to care and adjust the care plan accordingly. . . . Goals should "RUMBA". R=reasonable, U=Useful, M=Measurable, B=behavioral, A=attainable. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included multiple sclerosis, peripheral vascular disease, and anxiety. The physician's orders included the following medications; Lexapro (an anit-depressant to treat depression and anxiety), Alprazolam (an anti-anxiety), Tylenol Arthritis (for mild to moderate pain), Gabapentin (for nerve pain), and Oxycodone (an opioid for moderate to severe pain). During observation of medication administration on the morning of 08/10/21, the nurse (#4) stated, "When you see me give her [Resident #3] her medications, you will hear me say they are for her headache or she will not take them. Her family says we need to say that so she takes her pills." During an interview on 08/11/21 at 11:34 a.m., an administrative staff member (#2) stated, "We [facility staff] have to be careful how we present [the medications] or she [Resident #3] will not take them [her prescribed medications]." The staff (#2) also stated, Resident #3's family requested the facility refer to her medications as pills for her headache in an effort to improve medication compliance. Resident #3's care plan failed to include a	F 657	and pressure sore. Resident #26 care plan was updated self-administration of medications and independent use of automatic heating pad. 2. All residents have the potential to be affected by the facilities ability to develop and revise comprehensive care plans to ensure continuity of care of each resident. 3. All current residents care plans will be reviewed to ensure they are up to date. All care plans will be on a monthly review/revise schedule with nursing. Staff will be re-educated on how to develop and revise a care plan to ensure continuity of care at the mandatory all staff meeting 8/30/21. 4. QI monitoring will be implemented for residents #3, #9, #11, #16, #20, and #26 care plans along with 2 random residents to ensure that their care plan addresses current care needs; random areas of the care plans will be used for QI monitoring. QI monitoring will be done by DON/QI designee weekly X4, then monthly x 2, then quarterly x2 unless determined otherwise by the QI committee at the monthly meeting. 5. 8/30/21	

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F 657	Continued From page 11	F 657		

problem for pain and to identify signs/symptoms of possible adverse reactions secondary to anti-depressant, anti-anxiety, and opioid use. The care plan also lacked documentation of the family request for staff to inform Resident #3's medications are for headaches.

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included major depression and anxiety. The physician orders included the following medications; Seroquel (anti-psychotic), Ativan (anti-anxiety), and Lexapro (anti-depressant).

Resident #8's care plan lacked a diagnosis of depression and the use of an anti-depressant and anti-psychotic medications.

- Observation on 08/10/21 at 11:06 a.m. showed a plastic medication cup containing pills located on Resident #9's overbed table. The Resident #9 identified the pills as vitamins, and stated, "They leave them for me so I can take them throughout the day."

Review of Resident #9's medical record occurred on all days of survey. The resident's care plan lacked documentation for self-administration of medications.

- Review of Resident #11's medical record occurred on all days of survey. Diagnoses included breast cancer, chronic depression, and increased intracranial pressure (ICP) (pressure within the skull). The current physician orders included the following medications; Letrozole (to treat breast cancer), Celexa (an anti-depressant), and Keppra (to prevent seizures related to ICP).

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F 657	Continued From page 12 The record also showed long term use of a Foley catheter. Resident #11's care plan lacked a problem for cancer, ICP, and Foley catheter use. The care plan also lacked signs/symptoms of possible adverse reactions secondary to use of an anti-depressant and use of medications to treat cancer and to prevent seizures. - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included intellectual disabilities (disability in mental capacity). The quarterly Minimum Data Set (MDS), dated 06/01/21, identified a BIMS (Brief Interview for Mental Status) of 12, indicating a moderately impaired cognitive status (the mental processes involved in gaining knowledge and comprehension). During an interview on 08/09/21 at 9:03 a.m., Resident #16 stated, "I want out of here [the facility]." During an interview on 08/11/21 at 8:14 a.m., an administrative staff member (#3) stated Resident #16 talked about discharge during their conversations, and later "he changes his mind." During a telephone interview, on 08/11/21 at 8:24 a.m., Resident #16's Power of Attorney (POA) stated the resident has talked about leaving the facility for years and the POA tells the resident he/she can leave the facility when he/she is able to walk and take care of himself. The POA further stated the resident would never leave the local area.	F 657		

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F 657	Continued From page 13 The current care plan lacked documentation on how the facility addresses Resident #16's continued requests to discharge from the facility. - Review of Resident #20's medical record occurred on all days of survey. The quarterly (MDS), dated, 07/23/21 identified weight loss and a stage 3 pressure ulcer. The current care plan identified, ". . . Problem: Underweight. Goal: Eats a specific percentage of meals. . . . Problem: Pressure ulcer: unstageable. Goal: skin will remain intact. . . ." Resident #20's care plan lacked a measurable and personalized goal for weight loss and pressure ulcer. - Review of Resident #26's medical record occurred on all days of survey. Diagnoses included diabetic retinopathy (damage to blood vessels of the eye), glaucoma (damage to the optic nerve), neuralgia (severe pain due to damaged nerves) and pain. Observations on 08/09/21 at 10:14 a.m. and 08/10/21 at 7:55 a.m. showed a partial box of single use containers of Refresh eye drops on the overbed table in Resident #26's room. The resident reported self-administration of Refresh eye drops as needed and stated he/she had numerous sinus surgeries due to eye pressure, his/her eyes become very dry, scratchy, and sensitive to light. Observation on 08/10/21 at 8:00 a.m. showed Resident #26 seated in a recliner chair with an automatic heating pad located on the right side of his/her neck and shoulder. Resident #26 reported	F 657		

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F 657	Continued From page 14 he/she will adjust the heating pad on or off as needed throughout the day. Resident #26's care plan lacked documentation for self-administration of medications and independent use of an automatic heating pad.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 4 of 4 residents (Resident #16, #22, #25, and #26) observed during insulin preparation and administration. Failure to properly disinfect insulin vials/pens and prepare/administer insulin per manufacturer recommendation may result in insulin contamination and the resident receiving an inaccurate dose of insulin. Findings include: The manufacturer's instructions for the NOVOLOG® FlexPen®, found at https://www.novomedlink.com/content/dam/novonordisk/novomedlink/resources/generaldocuments/NovoLog%20FlexPen%20IFU%20PDF_LOCKED.pdf, stated, ". . . NovoLog® . . . vial . . . Step 2. Wipe the rubber stopper with an alcohol swab .	F 658	Part 1 1. Education was provided to nurses on proper disinfecting of insulin stoppers and any items that have been dropped on the floor and proper use/administration of insulin using an insulin pen. 2. All residents have the potential to be effected by the facilities failure to follow professional standards of practice of insulin preparation and administration. 3. Staff were educated on proper preparation and administration of insulin and disinfection of dropped supplies and will be re-educated at the mandatory all staff meeting 8/30/21. 4. QI monitoring will be done for residents #16, #22, #25, and #26 and randomly for any other residents on insulin daily X 5, weekly x 4, monthly x 2 and quarterly x 2 unless determined otherwise by the QI committee at the monthly meeting. During the QI	8/30/21

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F 658	Continued From page 15 . . Step 11. Insert the needle into your skin. Push down on the plunger to inject your dose. [The] Needle should remain in the skin for at least 6 seconds to make sure you have injected all the insulin. . . . NovoLog® FlexPen® . . . A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. . . . F. Hold the NovoLog® FlexPen® with the needle pointing up. . . . G. Keep the needle pointing upwards, press the push-button all the way in . . . J. Keep the needle in the skin for at least 6 seconds . . . This will make sure that the full dose has been given. . . ." - Observations of the staff nurse (#5) on 08/09/21 showed the following: * 5:07 p.m., the nurse inserted a needle into Resident #16's vial of NovoLog insulin and failed to disinfect the rubber stopper. * 5:13 p.m., the nurse obtained Resident #22's insulin pen and, without disinfecting the rubber stopper, attached a needle to the stopper. The nurse primed the insulin pen at an approximate 45 degree angle, injected the insulin, and removed the needle after 3 seconds. * 5:19 p.m., the nurse inserted a needle into Resident #26's vial of NovoLog insulin and failed to disinfect the rubber stopper. * 5:25 p.m., the nurse obtained Resident #25's insulin pen and, without disinfecting the rubber stopper, attached a needle to the stopper. The nurse primed the insulin pen at an approximate 75 degree angle, injected the insulin, and removed the needle after 3 seconds. - Observations of staff nurse (#4) on 08/10/21 showed the following: * 11:41 a.m., the nurse primed Resident #22's NovoLog insulin pen at a horizontal angle,	F 658	observation it will be monitored for any dropped supplies, if noted then that proper disinfecting is done. 5. 8/30/21 Part 2 1. Education was provided to nurses on proper medication administration using the 6 rights of medication administration. 2. All residents have the potential to be affected by the facilities failure to follow professional standards of practice regarding medication preparation and administration. 3. Staff were educated on the proper preparation and administration of medications using the 6 rights of medication administration and will be re-educated at the mandatory all staff meeting 8/30/21. 4. QI monitoring will be done for residents #6, #11, #15, #16 and #26 as well as 2 random residents medication pass daily x5, weekly x 4, monthly x 2 and quarterly x2 unless determined otherwise by the QI committee at the monthly meeting. 5. 8/30/21	

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F 658	Continued From page 16 injected the insulin, and removed the needle after 3 seconds. The insulin pen fell onto the floor. The nurse failed to disinfect the pen and placed it back into the medication cart. * 11:44 a.m., the nurse primed Resident #25's NovoLog insulin pen at a horizontal angle, injected the insulin, and removed the needle after 3 seconds. The insulin pen cover fell onto the floor. The nurse failed to disinfect the cover, placed the cover on the pen, and placed the pen back into the medication cart. During an interview on 08/10/21 at 10:23 a.m and at 3:01 p.m., an administrative nurse (#2) confirmed facility staff failed to disinfect the rubber stoppers on the insulin vials and pens, failed to prine insulin pens correctly, and failed to disinfect contaminiated items prior to returning them to the medication cart. MEDICATION ADMINISTRATION 2. Based on observation, review of professional reference, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 5 of 11 residents (Resident #6, #11, #15, #16, and #26) observed during medication pass. Failure follow professional standards for safe medication preparation and administration may result in medication errors and placed all residents at the risk for injury. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts,	F 658		

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F 658	Continued From page 17 pages 838-840, stated, ". . . Administering Oral Medications . . . Organize the supplies. Gather the MAR(s) [medication administration records] for each client together so that medications can be prepared for one client at a time. Rationale . . . reduces the chance of errors. . . . Safety . . . Label all medications, medication containers, and other solutions . . . Note: Medication containers include syringes, medicine cups, and basins, Rationale: Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original containers and placed into unlabeled containers. . . . " - Observations of the medication pass on 08/10/21 showed the following: * 7:49 a.m., an unlabeled plastic medication cup with pills and an unlabeled pre-filled insulin syringe located in Resident #26's drawer in the medication cart When asked the nurse (#4) how he/she knew the medications were for Resident #26's, the nurse stated, "because the medications were dished up and placed in the drawer with his [the resident's] name. I drew the insulin in the room [medication room] and placed it in his [the resident's] drawer [in the medication cart]." * 8:04 a.m., an unlabeled plastic medication sleeve with pills located in Resident #11's drawer in the medication cart. When asked the nurse (#4) how he/she knew the medications were for Resident #11, the nurse brought up the resident's medication record on	F 658		

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F 658	Continued From page 18 the computer screen, counted the number of scheduled 8:00 a.m. medications, and confirmed that number with the number of pills in the sleeve. * 8:30 a.m., an unlabeled plastic medication cup with pills located in Resident #6's drawer in the medication cart. * 11:25 a.m., the nurse (#4) mixed Resident #16's liquid medication with water in a plastic drinking cup. The nurse placed the unlabeled cup of medication on top of the medication cart in the medication room and began to administer medications to other residents. * 11:57 a.m., the nurse (#4) removed an unlabeled nicotine transdermal patch from Resident #15's drawer in the medication cart. When asked the nurse (#4) how he/she knew the patch was for Resident #15, the nurse stated, "I took it [the patch] from the bottom drawer [of the medication cart] from a box with her [Resident #15's] name on it and then put it in the drawer with her [the resident's] name on it." The nurse indicated she prepared this medication earlier in the day. During an interview on 08/10/21 at 8:22 a.m., the staff nurse (#4) stated she always predishes the morning medications and insulins. "There's so much [to do. If I don't] then I get behind." During an interview on 08/10/21 at 10:23 a.m., an administrative nurse (#2) stated it is not the facilities policy to predish medications, this included insulins.	F 658		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/30/21

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F 880	Continued From page 19 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 20 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's directions, review of professional reference, and staff interview, the facility failed to ensure staff followed standard infection control practices for 3 of 3 residents (Resident #22, #25, and #26) observed during blood glucose tests with a shared blood glucose meter. Failure to clean and disinfect shared	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency.	

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F 880	Continued From page 21 glucose meters and glucose testing supply surfaces has the potential for cross-contamination and may result in the transmission of blood-borne pathogens to other residents. During the recertification survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on the evening of 08/09/21. The IJ potential resulted from observation of a staff nurse (#5) failing to disinfect a shared blood glucose meter between residents. These findings placed residents in immediate danger due to the potential for cross contamination with a blood-borne pathogen and the need for education on disinfecting a shared blood glucose meter between residents. * 08/09/21 at 5:44 p.m., 5:50 p.m., and 6:15 p.m. - The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. * 08/09/21 at 6:20 p.m. - The survey team notified the Director of Nursing of the IJ situation and requested they develop a plan for abatement of the immediate jeopardy. * 08/09/21 at 7:35 p.m. - The facility provided a written plan of correction (via email) for the IJ. * 08/10/21 at 8:22 a.m. - The survey team reviewed and accepted the facility's revised version of the written plan of correction for the IJ. * 08/10/21 at 8:48 a.m. - The survey team abated and reduced the IJ situation from a	F 880	The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff use appropriate protocols to clean and disinfect blood glucose supplies, including blood glucose meters, between each resident use. The individual nurse was immediately educated on the cleaning and disinfection of blood glucose meters. All other personnel working at the time who perform blood glucose testing, including oncoming PM staff, were also immediately educated. The Director of Nursing (DON) immediately initiated a QA monitoring form, and after verbal education to staff, monitored the staff's return demonstration of proper technique. (2) Ensuring staff place blood glucose supplies, including glucose meters, on clean surfaces and to clean and disinfect supplies that may encounter contamination. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate all licensed personnel who perform blood glucose testing on appropriate protocols to clean and disinfect blood glucose supplies, including blood glucose meters between each resident use to prevent cross-contamination and transmission of blood-borne pathogens to other residents.	

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F 880	Continued From page 22 scope/severity of J to a scope and severity of D. * 08/10/21 at 9:08 a.m. - The SSA notified the regional office of the immediate jeopardy abatement. Findings include: Review of The Food and Drug Administration's (FDA) guidance for manufacturers regarding appropriate products and procedures for cleaning and disinfection of blood glucose meters, from the FDA's website (http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm227935.htm), stated, "Point of care blood testing devices such as blood glucose meters should be used only on one patient and not shared. If dedicating blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after every use following the guidelines provided in device labeling. . . . The disinfection . . . should be effective against HIV, Hepatitis C, and Hepatitis B virus. Outbreak episodes have been largely due to transmission of Hepatitis B and C viruses. However, of the two, Hepatitis B virus is the most difficult to kill. Please note that 70% ethanol solutions are not effective against viral bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device." Review of the Manufacturer's User Manual for the Clarity BG1000 Blood Glucose Monitoring System stated, ". . . Cleaning and Disinfecting. The meter should be cleaned and disinfected to prevent the transmission of blood borne	F 880	(2) Educate all licensed personnel who perform blood glucose testing on policy/procedure for placing blood glucose testing supplies on clean surface areas and to clean/disinfect any supplies that may become contaminated. (3) To verify staff understands the training, the staff will complete a return demonstration of proper use of/techniques for cleaning and disinfecting blood glucose supplies, including meters and supply surface areas. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review and evaluate the facility's compliance with the guidelines and manufacturer recommendations for cleaning/disinfecting for the glucose meters, supplies, and surface areas. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 09/10/2021 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to clean and disinfect shared glucose meters per manufacturer recommendations between each resident use. b. Failure to clean and disinfect blood glucose testing supplies/surfaces with	

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F 880	Continued From page 23 pathogens as follows. Cleaning is to remove germs, dirt, and impurities from surfaces or objects. Disinfection is to kill germs on surfaces or objects. . . . Cleaning Instructions: Use CaviWipes® towelette [a cleaner/disinfectant that is effective against many harmful organisms] to wipe the meter exterior of the front, the back and sides thoroughly. Disinfection Instructions: The meter must be cleaned and disinfected between patient uses by wiping it with a CaviWipes® Towelette in between tests. After cleaning the meter with a CaviWipes® Towelette use a second CaviWipes® Towelette to thoroughly wet the pre-cleaned meter surface. Allow it to remain wet for two minutes at 68 degrees F [Fahrenheit] as specified by the manufacturer of the disinfectant wipes and allow to air dry." Observation on 08/09/21 at 4:44 p.m., 4:58 p.m. and 5:25 p.m., showed a staff nurse (#5) carried a basket containing blood glucose testing supplies, including a glucose meter, to separate areas of the facility to check Residents #22, #25 and #26's blood glucose level. The nurse placed the basket on a non-sanitized surface, checked a resident's blood glucose level, and without disinfecting the glucose meter, placed the meter back into the basket, and without disinfecting the basket, carried the basket to the next resident. The nurse (#5) failed to disinfect the glucose meter between residents and before placing it back in the basket and failed to disinfect the exterior of the basket between surfaces and locations. Review of the facility policy titled "ASSURE 3 BLOOD GLUCOSE METER' occurred on	F 880	each use. (2) The DON, SDC, IP or suitable designee will ensure the following: a. All licensed personnel who perform blood glucose testing receive education regarding the updated policy on cleaning and disinfecting shared glucose meters in between residents. b. All licensed personnel who perform blood glucose testing to place glucose testing supplies on clean surfaces and to immediately clean and disinfect any supplies that may encounter contaminated surfaces. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Development of QA monitoring forms (2) Observations of all personnel who perform blood glucose testing to ensure blood glucose meters, blood glucose testing supplies and surface areas are clean and disinfected in accordance with manufacturer instructions and facility policy. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355034	A. BUILDING _____ B. WING _____	08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 24 08/09/21 stated, ". . . To clean the outside of your Assure 3 meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol, or diluted bleach (dilute 1 ml sodium hypochlorite in 99 ml of water to achieve 1:100 dilution). . . ." The facility policy failed to identify the blood glucose meter currently used by the facility (Clarity BG1000 Blood Glucose Monitoring System) and also failed to identify the CaviWipes® towelettes the facility uses to clean and disinfect the blood glucose meter. During an interview on 08/09/21 at 6:24 p.m., an administrative nurse (#2) stated she expects facility staff to disinfect the blood glucose meter between each resident use and prior to placing it back into the supply basket. The nurse (#2) also stated the facility staff are expected to lay down a paper towel or sanitize the area prior to setting the blood glucose supplies/basket down.	F 880	the involved staff. Such education will be documented on the QA monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 8/30/21	