

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451	
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F 000	INITIAL COMMENTS Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/23/15 through 6/25/15. Golden LivingCenter - Ipswich was found not in compliance with the following requirements: F176, F280, F281, F309, F323, F371, F425, F441, F490, F514, and F520.	F 000	<i>Addendums noted with an asterisk per 7/22/15 and 7/23/15 email and telephone from facility administrator. DW/sooah/JJ</i> Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
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: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to follow their policy for resident self-administration of medications for one of nine sampled residents (5). Findings include: 1. Observation on 6/23/15 at 7:50 a.m. during initial tour of resident 5's room revealed: *One foil packet of Ipratropium (for breathing) nebulizer treatment medication containing three unit doses. *One Asmanex inhaler (breathing medication). *One Spiriva inhaler (breathing medication). *Two cans of Desenex (antifungal) powder. Observation and interview with resident 5 in his room on 6/23/15 at 4:25 p.m. revealed:	F 176	F176 - RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE 1. R5 orders obtained for nitroglycerin tabs to be self administered /kept at bedside and other medications removed. Self administration of oral medication assessment completed. All residents have the potential to be affected. 2. Sweep of all residents rooms conducted on 6/20/15 for unauthorized medications at bedside and removed as appropriate. Nursing staff inserviced on the policy of medications at bedside. * 5 random DW/sooah/JJ 3. DNS/designee will audit resident's room for medications at bedside weekly x 4 weeks then monthly x 2 for compliance. QA committee to determine continued action and monitor compliance. * DON will report to QA monthly. DW/sooah/JJ 4. Substantial compliance achieved	7/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

ED

7-17-15

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

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F 176	<p>Continued From page 1</p> <p>*He had physician orders to keep medications in his room.</p> <p>*He was able to do his own nebulizer treatments after the nurse set it up.</p> <p>*In his bathroom he had:</p> <ul style="list-style-type: none"> -One can of Desenex powder. -One can of Zeasorb (antifungal) powder. -One bottle of Vitamin D3, 2000 units (dosage) softgels (pills) that was one-fourth full. -Another bottle of Vitamin D3, 2000 units softgels that was one-fourth full and had expired in December 2014. <p>Further observation and interview of resident 5 in his room on 6/24/15 at 1:45 p.m. revealed he:</p> <p>*Had not used the vitamins that were in his bathroom recently but had taken them in the past.</p> <p>-A friend brought them in for him.</p> <p>*Had "Nitro" (Nitroglycerin, medication for chest pain) in his room.</p> <p>*Got a prescription bottle with the Nitroglycerin 0.4 milligrams (mg) (dosage) sublingual (SL) (under the tongue) from his drawer in the bedside stand.</p> <p>*Stated the last time he had taken the Nitro was a couple weeks ago.</p> <p>-Stated after he took it he would have let the nurses know, so they could document.</p> <p>-Did not recall them taking his vitals signs (pulse [heart rate] and blood pressure) after he had reported he had taken it.</p> <p>Interview on 6/24/15 at 2:30 p.m. with licensed practical nurse A regarding resident 5 revealed:</p> <p>*She had been aware he had medications in his room that included inhalers, nebulizers, and Nitro.</p> <p>*He should not have had medications in his room without a physician's order.</p> <p>*She stated he told the nurses when he took the</p>	F 176		
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F 176	<p>Continued From page 2</p> <p>Nitro, and they would have checked his vital signs. *She reviewed his medication administration record (MAR) for the last time he had used the Nitro. -It had been ordered by the physician on 4/15/15, but it had not been documented as administered since it was ordered.</p> <p>Review of resident 5's current physician's orders revealed: *He could self administer the nebulizer treatments after it was set up by the nurse or medication aide. *He could keep inhalers at his bedside. *He had an order for Nitro 0.4 mg SL as needed. -It did not say or state it was okay to keep the Nitro at his bedside. *There was no order for the Desenex or Zeasorb powder. *There was no order for the Vitamin D3, 2000 unit softgels.</p> <p>Review of resident 5's May 2015 and June 2015 MARs revealed no documentation he had taken the Nitro as needed.</p> <p>Review of resident's 5's medical record revealed: *He had a Brief Interview for Memory Score (BIMS) (memory test) of fifteen that indicated he had no memory problems. *A Self Administration of Medications Assessment form had been completed on 4/30/15 and was reviewed on 5/27/15 by nursing. That assessment revealed: -He "may self-administer nebulizer treatments after set up by the nurse or med aide." -He "may keep inhalers at bedside." -There was no mention of the Nitro, Desenex, or</p>	F 176		

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F 176	<p>Continued From page 3 Vitamin D3.</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and the DON from another facility regarding resident 5 revealed they agreed: *He should have had an order from the physician for any medications in his room. *Any medications he had in his room and was taking by himself should have been included on the self-administration medication assessment.</p> <p>Review of the contract pharmacy's May 2012 Bedside Medication Storage policy revealed "A written order for the bedside storage of medication is present in the resident's medical record."</p> <p>Review of the contract pharmacy's May 2012 Self-Administration of Medications policy revealed: *"A. If the resident desires to self administer medications, an assessment is conducted by the interdisciplinary team..." *"D...For each medication authorized for self-administration, the label contains a notation that it may be self-administered."</p>	F 176		
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the</p>	F 280	<p>F280 – RIGHT TO PARTICIPATE PLANNING CARE</p> <ol style="list-style-type: none"> R 1, 2, 4, 5, 6 and 7 care plans reviewed and updated as appropriate. All residents have the potential to be affected . Care plans reviewed on the resident identifier list and are current. Care plans are reviewed quarterly and updated as appropriate. Inserviced nursing staff on the care plan process. <i>*All nurses are responsible and MQS Coordinator/RNAC is responsible for scheduled quarterly review.</i> 	<p><i>DW/5000H/JT</i></p>

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F 280	Continued From page 4 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure the careplans reflected the current status of six of nine sampled residents (1, 2, 4, 5, 6, and 7). Findings include: 1. Review of resident 1's undated care plan revealed: *Surgical wound to left hip that had not healed. *There was no documentation related to the burn area on her mid-abdominal (stomach) area. *Monitor for signs and symptoms of infection such as swelling, redness, warmth, discharge, and odor. Notify physician of significant changes. *ProPass protein supplement three times a day to aide in wound healing. *Skin assessment to be completed per policy. *Weekly wound assessment. *Would maintain skin integrity from further breakdown. *Alteration in bowel elimination related to constipation.	F 280	3. DNS/designee will conduct random audit of five care plans for accuracy weekly x 4, then monthly x 2. QA committee to determine continued action and monitor compliance. <i>Don will report to QA monthly. DW/soah JJ</i> 4. Substantial compliance achieved	7/17/15
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F 280	<p>Continued From page 5</p> <ul style="list-style-type: none"> *Bowel medication as ordered. Monitor use and effectiveness. *Monitor bowel status frequently per care tracker. **"I will have a soft formed bowel movement at least every three days." **"Resident is at nutritional risk related to a therapeutic [beneficial] diet and overweight/obesity." *Weight would decrease or remain stable. *Encourage three meals per day. *Non compliant with diet at times. *Refused meals at times. *Refused to come out to the dining room at times. *Would monitor weights as available. *There was no documentation related to her significant weight loss and poor intake for most meals. <p>Refer to F309, finding 1.</p> <p>Surveyor: 32572</p> <p>2. Review of resident 2's undated care plan revealed all focus areas had goal dates of 9/11/15.</p> <ul style="list-style-type: none"> *A focus area of physical functioning deficit. *Interventions: <ul style="list-style-type: none"> -Extensive assistance of one staff person for personal hygiene, toileting, and transferring. *A focus area of urinary tract infection. *Interventions of: <ul style="list-style-type: none"> -"Urine is ESBL [extended spectrum beta-lactamase-difficult to treat infection] +[positive]. Contact Isolation [specific precautions to take when caring for the resident]." <p>Review of resident 2's 5/28/15 Minimum Data Set (MDS) Assessment revealed personal hygiene, toileting, and transfer assistance had been coded as limited staff assistance of one.</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>Random observations from 6/23/15 through 6/25/15 revealed no indication on the resident's door to report to the nurses station prior to entering or that the resident was to have been in contact isolation.</p> <p>Review of the daily report sheet did not indicate the resident had been on contact precautions.</p> <p>Surveyor: 22452 3. Review of resident 4's 5/13/15 through 6/24/15 weight record revealed: *5/13/15- 149 pounds (lb). *6/17/15- 139 lb. *6/23/15- 137 lb.</p> <p>Review of resident 4's 5/12/15 physician's progress notes revealed: *Staff had documented: -Resident declining, more anxious, and becoming combative. -Staff have to assist with feeding. -Current weight was 145 lb and weight the prior month was 142 lb. *Physician had documented dementia (memory loss) with behavioral changes.</p> <p>Review of resident 4's 6/5/15 dietitian's progress notes revealed: **"Resident is on a regular diet with small portions." **"Weight has been stable for the last six months." **"Current weight is 142 lb."</p> <p>Review of resident 4's undated care plan revealed: **"Resident is at nutritional risk related to the diagnosis of dementia."</p>	F 280		
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F 280	<p>Continued From page 7</p> <p>***"Weight will remain stable." ***"Provide assistance with meals if needed."</p> <p>Surveyor: 35237</p> <p>4. Review of resident 5's last revised 6/17/15 care plan revealed: *A focus area of advanced directive: Full Code (do CPR, see below). *Interventions were: -"CPR [cardio pulmonary resuscitation, a life saving measure used if a person was found without a pulse (heart beat) or breathing] will be performed as ordered." -"Review code status quarterly."</p> <p>Review of resident 5's medical record revealed: *A 4/16/15 Resuscitation Orders form signed by the resident and his physician. That form indicated he did not want CPR initiated if he had of a cardiac and/or respiratory arrest (not having a pulse or breathing).</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and the DON from another facility confirmed resident 5's current care plan did not reflect his wishes for no CPR. They agreed that form had been signed on 4/16/15, but the care plan had not been updated for that change.</p> <p>5. Review of resident 6's last revised 4/16/15 care plan revealed: *A focus area of "Alteration in elimination of bowel and bladder, Indwelling urinary catheter [a tube inserted into the bladder to drain urine]." -The date initiated had been 11/20/14. -Interventions for the focus area had been last revised on 2/10/15. *A focus area of "I have a physical functioning</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>deficit [unable to move on own]" last revised on 3/5/15.</p> <p>-Interventions for that focus area included:</p> <p>-For bed mobility (moving in bed), dressing, personal hygiene, and toileting he required extensive assistance of two staff.</p> <p>-For transfers he required a mechanical lift (equipment to move resident from one area to another) and extensive assistance of two staff.</p> <p>Review of resident 6's medical record revealed:</p> <p>*A physician telephone order discontinued the urinary catheter on 5/27/15.</p> <p>*A 2/10/15 Lift/Mobility Assessment form indicated:</p> <p>-He had been unable to bear weight on at least one leg and was not a candidate for the Sara (a stand-up type of equipment used to transfer from one place to another) lift.</p> <p>-He had been a candidate for the Maxi or Marisa (a total lift used to transfer from one place to another) lift.</p> <p>*There were no more recent lift assessments found in the record.</p> <p>Observation on 6/23/15 at 4:50 p.m. of resident 6's transfer with certified nursing assistant (CNA) P revealed:</p> <p>*He did not have a urinary catheter.</p> <p>*He was wearing a disposable brief.</p> <p>*He declined to use the bathroom at that time.</p> <p>*She used the Sara lift (stand-up type) to transfer him from his bed to the wheelchair.</p> <p>Observation on 6/24/15 at 8:58 a.m. of resident 6's transfer with CNA Q revealed:</p> <p>*He had been in the bathroom sitting on the toilet with the Sara lift still in place.</p> <p>*After she raised him to a standing position in the</p>	F 280		
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F 280	<p>Continued From page 9</p> <p>lift she performed personal care. *She then assisted him into his wheelchair using the lift. *She stated he could be assisted with one or two staff.</p> <p>Review of resident 6's 5/1/15 quarterly Minimum Data Set assessment (MDS) revealed: *He required extensive assistance of two staff for bed mobility, transfers, and toileting. *He required extensive assistance of one staff person for dressing and personal hygiene.</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim DON and the DON from another facility regarding resident 6's care plan confirmed: *His care plan had not been updated since his urinary catheter had been discontinued 5/27/15. *They agreed the care plan and MDS indicated he required the assistance of two staff, and that did not reflect his current status.</p> <p>Review of the provider's 1/26/15 Transfer Activities policy revealed: *Documentation guidelines included: -"Amount of assistance resident requires." *Care plan documentation guidelines included: -"List instructions unique to this resident."</p> <p>Surveyor:32572</p> <p>6. Review of resident 7's undated care plan revealed inconsistent information with the printed care plan at the nurses station and the care plan in the electronic medical record. Refer to F323, finding 1.</p> <p>Interview on 6/23/15 at 2:00 p.m. with the DON revealed the most current care plans would have been in the electronic medical record they had</p>	F 280		
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F 280	<p>Continued From page 10 printed for the surveyors.</p> <p>Surveyor: 35237 A care plan policy was requested from the administrator and was not received by the end of the survey.</p> <p>A copy of the April 2012 Resident Assessment Instrument manual, Section V. Care Area Assessment (CAA) Summary was received from the provider and related to care plans revealed: "The MDS does not constitute a comprehensive assessment. Rather it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning."</p>	F 280		
F 281 SS=G	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 A. Based on observation, record review, interview, and policy review, the provider failed to ensure: *The physician was notified of no improvement in a burn area for one of one sampled resident (1). *The policy for weekly skin assessment and documentation was followed for one of one</p>	F 281	<p>F281 – SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <ol style="list-style-type: none"> 1. R1 physician was updated on abdominal wound with a change in treatment obtained. The wound is healed. 1a. R1 order for C-diff collected and was negative. 1b. R4 CBC was completed 1c. R5 Nitro patch received and has had patch applied as ordered 1d. R8 direction for daily weight includes call MD if >3 pound weight gain and weights are being done daily <p>All residents have the potential to be affected.</p>	

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F 281	<p>Continued From page 11 sampled resident (1). Findings include:</p> <p>1. Review of resident 1's 6/8/15 discharge hospital instructions revealed "Coffee burn to mid-abdomen [stomach] that was present on admission from nursing home."</p> <p>Review of resident 1's medical record revealed: *Documentation on the abdominal wound was done on 6/13/15 and not again until 6/25/15 when the wound was observed by the surveyor during a dressing change. *The physician was updated on 6/25/15 after the dressing change was observed by the surveyor. Refer to F309, finding 1. Surveyor: 32572</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to maintain professional standards for the following: *Follow-up of physicians' order's for four of nine sampled residents (1, 4, 5, and 8). *Follow-up of pharmacists' recommendations for four of nine sampled residents (2, 7, 8, and 9). *Follow-up of dieticians' recommendations for three of nine sampled residents (1, 4, and 8). *Follow-up of laboratory (lab) tests drawn for one of nine sampled resident (5). Finding include:</p> <p>Surveyor: 22452</p> <p>1a. Review of resident 1's 6/9/15 nursing progress notes revealed "Resident complains of having diarrhea. Order received for stool to be checked for Clostridium Difficile [C-diff, infection easily spread and usually appears in patients [residents] taking antibiotics or hospitalized. Requires bleach to kill organism]."</p>	F 281	<p>2a. R2 Reglan has been discontinued</p> <p>2b. R7 Consultant pharmacist reviewed chart on 6/26 and one recommendation sent to MD</p> <p>2c. R8 Consultant pharmacist reviewed chart on 6/26 with no recommendations</p> <p>2d. R9 Consultant pharmacist reviewed chart on 6/26 with one recommendation sent to MD</p> <p>3a. R1 dietary recommendation for pre-albumin/albumin and start house supplement obtain and implemented</p> <p>3b. R4 diet order changed from small portions to regular portions and order for house supplement obtained</p> <p>3c. R8 diet for ConcCHO with cut up meat was discontinued on 6/3/15 and diet of heart healthy pureed started on 6/3/15 (was receiving correct diet when observed during survey), receiving house supplement and lab work was obtained</p> <p>3d. R5 PT/INR's and Coumadin are being done and given as ordered</p> <p>2. All new orders are being reviewed for accuracy by DNS/designee daily Consultant pharmacist reviewed all resident's charts and recommendations sent to the physicians - follow up being done by the DNS Dietary recommendations reviewed by DNS/designee and weights are reviewed on a weekly basis by dietary manager/DNS All resident's lab orders reviewed and are current. Nurses inserviced on the pharmacy and dietary recommendation/weight process and following/transcribing physician orders</p> <p>3. DNS/designee will conduct random audits of [#]all new physician orders three times a week x2 weeks, ^{DW/SaooH/JJ} two times a week x 2 weeks, then weekly x 2 months. Dietary manager/designee will audit [#]dietician ^{DW/SaooH/JJ} recommendations response weekly until all recommendations are responded to by the physician x 3 months. DNS/designee will monitor [#]pharmacy ^{DW/SaooH/JJ} recommendation response weekly until all recommendations are responded to by the physician x 3 months.</p>	
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F 281	<p>Continued From page 12</p> <p>Review of resident 1's 6/9/15 through 6/24/15 bowel movement record revealed: *There was no documentation the stool ordered on 6/9/15 for C-diff had been obtained. *She had ten episodes of diarrhea. *Two of the diarrhea stools had been incontinent (loss of control).</p> <p>Interview on 6/24/15 at 2:00 p.m. with the interim director of nursing (DON) regarding resident 1 revealed she: *Was unable to find any documentation why the stool had not been obtained as ordered by the physician. *Was not working at the facility until 6/23/15.</p> <p>b. Review of resident 4's 6/12/12 physician's orders revealed "Complete Blood Count [measures several parts of blood including red blood cells that carry oxygen] every three months."</p> <p>Review of resident 4's medical record revealed the last complete blood count was obtained on 12/1/14.</p> <p>Interview on 6/24/15 at 3:30 p.m. with the interim DON regarding resident 4 revealed she: *Was unable to locate any documentation in the medical record if the complete blood count had been obtained or why it had not been done. *Had checked with the laboratory, and they had no record the blood specimen had been obtained.</p> <p>Surveyor: 35237</p> <p>c. Review of resident 5's medical record revealed he: *Had an order for Nitro-Dur (nitroglycerin, used to prevent chest pain) patch every twenty-four hours</p>	F 281	<p>QA will determine continued action to monitor compliance. * DON will report to QA monthly. <i>06/15/2015 HJJ</i></p> <p>4. Substantial compliance achieved</p>	7/17/15
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F 281	<p>Continued From page 13 for chest pain.</p> <p>*Had an electronic medication administration record (MAR) note from 6/23/15 at 11:15 a.m. that indicated the medication was "not here, coming from backup."</p> <p>*Had an electronic MAR note for 6/24/15 at 7:23 a.m. that indicated the medication was "not here."</p> <p>*There was no mention of further contact with the pharmacy.</p> <p>*There was no mention of physician notification of the medication not being used yet.</p> <p>*There was no documentation the resident had been assessed for chest pain.</p> <p>Review of resident 5's June 2015 MAR revealed:</p> <p>*He had not received the Nitro patch on 6/23/15.</p> <p>*He did receive the Nitro patch on 6/24/15 at 2:38 p.m.</p> <p>Interview on 6/24/15 at 2:30 p.m. with licensed practical nurse (LPN) A regarding resident 5 revealed the Nitro patch was not available. It had been ordered from the pharmacy on 6/23/15.</p> <p>Further interview on 6/25/15 at 11:15 a.m. with LPN A regarding resident 5 revealed:</p> <p>*She confirmed the Nitro patch had not been given for one and one-half days.</p> <p>*The physician had not been notified of the above.</p> <p>*Normally if a medication was unavailable the nurse would have called the pharmacy.</p> <p>*She had called the pharmacy on 6/23/15 but had not documented that.</p> <p>*It usually took at least two days to get a medication from the pharmacy, if it was not in the medication dispensing machine at the facility.</p> <p>*Occasionally they received medications from a local pharmacy.</p>	F 281		
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F 281	<p>Continued From page 14</p> <p>*She agreed the Nitro patch was an important medication and could have had an effect on the resident when it had not been given.</p> <p>*She confirmed she had not assessed the resident's vital signs (blood pressure and pulse[heart rate]) or chest pain after he not received the Nitro.</p> <p>-She stated he had an appointment at the clinic, so they would have done vitals there.</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and the DON from another facility regarding resident 5's Nitro patch revealed:</p> <p>*They agreed not getting that medication could have a negative effect on the resident.</p> <p>*They would have expected the nurse to contact the pharmacy.</p> <p>*They would have expected the medication to be available within twenty-four hours.</p> <p>*If the pharmacy was unable to get the medication to the facility they should have gotten it from a backup pharmacy.</p> <p>Surveyor 32572</p> <p>d. Review of resident 8's medical record revealed:</p> <p>*She had been recently re-admitted on 6/3/15 after a hospital stay.</p> <p>*The physician had ordered "Daily weights and to notify the physician if weight gain of three pounds or more, because the Lasix (fluid medication) was being held."</p> <p>Review of the June 2015 electronic MAR revealed a physician's order that stated "Daily weights one time a day related to hypertension." The order had not indicated to notify the physician with a weight gain of 3 pounds (lb.) Review of the</p>	F 281		
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F 281	<p>Continued From page 15</p> <p>weights recorded on the MAR revealed:</p> <ul style="list-style-type: none"> *6/8/15-138 lb. *6/9/15-no weight had been recorded. *6/10/15-140 lb. *6/11/15-137 lb. *6/12/15-no weight had been recorded. *6/15/15-138 lb. *6/16/15-142 lb. *6/17/15-143.5 lb. *6/18/15-140 lb. *6/20/15-142 lb. *6/21/15-no weight had been recorded. *6/22/15-134 lb. <p>Review of resident 8's Weight and Vitals Summary record revealed:</p> <ul style="list-style-type: none"> *6/9/15-no weight recorded. *6/12/15-no weight had been recorded. *6/22/15-134 lb. <p>Review of the June 2015 interdisciplinary progress notes revealed no physician notification of weight changes.</p> <p>2a. Review of resident 2's pharmacists' recommendations revealed:</p> <ul style="list-style-type: none"> *1/21/15 a request for a gradual dose reduction (GDR). *March 2015 a statement of "re-issue Jan/Feb." *April 2015 a statement of "re-issue-Reglan [nausea medication] D/C [discontinue]." *5/26/15 a statement "Rec. [recommend] to D/C Reglan/Sanctura-pt [patient] mostly incontinent [loss of bladder control]." *Staff had not followed up on the recommendations from the pharmacist for resident 2 in a timely manner. <p>b. Review of resident 7's pharmacist</p>	F 281		
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F 281	<p>Continued From page 16 recommendations revealed: *10/30/14 a request to have specific laboratory tests (lab work). *11/24/14 the request had to be re-issued as requested in October 2014. *12/22/14 a request for GDR and re-issue for the lab work requested in October 2014. *1/21/15 re-issue for the requested labs in October 2014 and the GDR issued in December 2014. *March 2015, re-issue 1/15 (January 2015) and 2/15 (February 2015). No documentation in the chart as to what had been requested. **Staff had not followed up on the recommendations from the pharmacist for resident 7 in a timely manner.</p> <p>c. Review of resident 8's pharmacists' recommendation revealed March 2015 a statement "re-issue-from 1/15." *Staff had not followed up on the recommendations from the pharmacist for resident 8 in a timely manner.</p> <p>Surveyor: 35237 d. Review of resident 9's pharmacist's recommendations revealed: *February 2015 a request related to Tessalon Perles (cough medicine) and Reglan (stomach medicine). *March 2015 a statement of "re-issue Tessalon, Reglan" and a request for Vitamin D and lipids (cholesterol lab work). *April 2015 a statement of "re-issue Vit (Vitamin D and lipids)." *Staff had not followed up on the recommendations from the pharmacist for resident 9 in a timely manner.</p>	F 281		
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F 281	<p>Continued From page 17</p> <p>Surveyor: 32572</p> <p>e. Interview on 6/23/15 at 3:05 p.m. with the director of nursing (DON) revealed the process for follow-up had been:</p> <ul style="list-style-type: none"> *To fax the written pharmacists' request to the physician. *The request had been kept at the nurses station on a clipboard. *The request had been re-faxed to the physician every day if no response had been obtained. <p>Interview on 6/23/15 at 3:00 p.m. with the DON confirmed she had been ultimately responsible for the follow up of the pharmacists' recommendations.</p> <p>Review of the provider's May 2015 Documentation and Communication of Consultant Pharmacist Recommendation policy revealed "The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion."</p> <p>Surveyor: 22452</p> <p>3a. Review of resident 1's 1/9/15 through 6/23/15 Weights and Vitals Summary sheet revealed the following weights:</p> <ul style="list-style-type: none"> *1/9/15- 301 pounds (lb). *1/26/15- 299 lb. *3/10/15- 290 lb. *3/30/15- 290 lb. *5/4/15- 271.5 lb. *5/31/15- 255 lb. *6/23/15- 247.5 lb. 	F 281		
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F 281	<p>Continued From page 18</p> <p>Review of the above weights revealed resident 1 had:</p> <p>*Lost 24 lb from 5/4/15 to 6/23/15 which was an 8.8 percent (%) loss. (A 5% weight loss in one month was significant and weight loss greater than 5% was severe.)</p> <p>*Lost 7.5 lb from 5/31/15 to 6/23/15.</p> <p>Review of resident 1's 5/21/15 registered dietitian's (RD) progress notes revealed:</p> <p>***She was hospitalized from 5/5/15 to 5/12/15 for sepsis [blood infection]."</p> <p>***She is not eating well. Current intake is 47% breakfast, 10% lunch, 1% supper, and 14% snack. She has lost weight as a result of her poor intake."</p> <p>***Current weight is 271.5 lb. She lost 18.5 lb since March 2015 and 29.5 lb in six months. She is baseline with her weight one year ago and a admission."</p> <p>***Total nutrition intake does not meet estimated needs."</p> <p>***Inadequate oral intake, inadequate protein intake, and unintentional weight loss."</p> <p>***Unplanned weight loss related to inadequate intake evidenced by 9.8% weight loss in six months and 29.5 lb."</p> <p>***She is morbidly [severely] obese even with weight loss."</p> <p>***She has several wounds."</p> <p>***Previously she was extremely non-compliant with her written meal plan and now she is just not eating."</p> <p>***RD will add enrichment to her meal plan and recommends 8 ounces of house supplement three times a day. She has refused this in the past along with Propass [powder protein supplement], but RD wants to try again."</p>	F 281		
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F 281	<p>Continued From page 19</p> <p>"RD will have certified dietary manager fax this request to the physician for review."</p> <p>"Nutrition goals are weight stable and wound healing."</p> <p>Review of resident 1's dietary card and May 2015 through June 2015 medication administration records revealed no documentation she had received the Propass powder or the dietary supplement.</p> <p>Phone interview on 6/25/15 at 8:30 a.m. with the consultant dietitian regarding resident 1 revealed she:</p> <ul style="list-style-type: none"> *Had not been informed the resident had been in the hospital from 6/4/15 through 6/8/15. *Had not been informed of her weight loss from 271.5 lb to 247.5 lb. *Was not aware they had not been following her 5/21/15 recommendation for house supplement TID. *Had informed the dietary manager of her recommendations. The usual dietary manager was on a medical leave, but she had informed the dietary manager that was filling in for her from another facility. <p>Interview on 6/23/15 at 2:00 p.m. with the DON regarding resident 1 revealed she:</p> <ul style="list-style-type: none"> *Knew they had not notified the dietitian of her continued weight loss since the dietitian had just assessed her 5/21/15. *Felt it had been the dietary manager's responsibility to get the orders for the nutritional supplement from the physician. *That was why nursing had not followed through on the recommendations. <p>b. Review of resident 4's 5/13/15 through 6/24/15</p>	F 281		
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F 281	<p>Continued From page 20 weight record revealed: *5/13/15- 149 pounds (lb). *6/17/15- 139 lb. *6/23/15- 137 lb.</p> <p>Review of resident 4's 5/12/15 physician's progress notes revealed: *Staff had documented: -Resident declining, more anxious, and becoming combative. -Staff have to assist with feeding. -Current weight was 145 lb and the weight for the prior month was 142 lb. *Physician had documented dementia (memory loss) with behavioral changes.</p> <p>Review of resident 4's 6/5/15 dietitian's progress notes revealed: **"Resident is on a regular diet with small portions." **"Weight has been stable for the last six months." **"Current weight is 142 lb."</p> <p>Interview on 6/24/15 at 2:30 p.m. with the interim director of nursing regarding resident 4 revealed she: *Was unable to locate any documentation the dietitian had been informed of her weight loss. *Was unsure why she was on small portions. *Was very confused and unable to state her preferences. *Had been eating well when fed according to the intake records.</p> <p>Surveyor 32572 c. Review of resident 8's 6/5/15 dieticians' nutritional assessment revealed: **"Nutritional needs did not meet estimated needs." *A recommendation to discontinue the heart</p>	F 281		
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F 281	<p>Continued From page 21 healthy diet and switch to a regular diet, puree [food made to a smooth consistency], with enrichment. Also to offer house supplement in the p.m. and at bedtime due to poor dietary consumption."</p> <p>Review of resident 8's 6/12/15 signed physician's orders revealed: **"Dietary-Diet: Conc [concentrated] CHO [carbohydrate] diet cut up meat texture, upgrade diet to regular consistency with meat cut into small pieces. -Heart Healthy diet puree texture, thickened liquid honey consistency." **"Laboratory: -BMP [basic metabolic panel (specific laboratory test)], Digoxin [specific laboratory test to measure medications], Serum Carbamazepine [specific laboratory test to measure medication] every six months."</p> <p>Random observations from 6/24/15 through 6/25/15 revealed resident 8 received a puree diet with honey consistency liquids at meals.</p> <p>Review of resident 8's Meal Intake Detail Report for 5/26/15 through 6/24/15 revealed: *She had eaten fifty percent or less of her breakfast twelve times. *She had eaten fifty percent or less of her lunch seventeen times. *She had eaten fifty percent or less of her evening meal twenty two times. *She had eaten fifty percent or less of her evening snack eighteen times.</p> <p>Review of the undated care plan with targeted goal dates of 9/16/15 revealed: *Focus area of at risk for weight loss.</p>	F 281		
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F 281	<p>Continued From page 22</p> <ul style="list-style-type: none"> -Intervention of "receives 4 oz [ounces] house supplement daily in the afternoon." *Focus area of Nutritional risk. -Interventions of: <ul style="list-style-type: none"> --"Daily weights." --"House supplement daily to assist in maintaining weight." --"Offer snacks between meals." --"Provide diet as ordered by physician." <p>Review of resident 8's medical record revealed: *The ordered laboratory (lab) tests had been completed on 11/11/14 and were due to be completed again May 2015. *There were no laboratory results for the ordered tests that had been due in May 2015.</p> <p>Review of the provider's 1/6/15 reviewed Lab Processing/Tracking Guideline policy revealed: **Monitoring/Compliance: -Labs are scheduled and drawn as per physician orders. -Evidence that the Diagnostic/Lab tracking tool is being utilized effectively. -Evidence of the lab process is monitored daily during clinical start-up."</p> <p>Interview on 6/25/15 at 11:07 a.m. with the interim director of nursing confirmed the labs that were due in May 2015 had not been completed.</p> <p>Surveyor: 35237</p> <p>4. Review of resident 5's medical record revealed: *A 6/2/15 lab report for Prottime (PT) and INR (International Normalized Ratio) (tests to monitor the blood thinning effect of warfarin [medication]) levels. -The INR result was indicated as low.</p>	F 281		
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F 281	<p>Continued From page 23</p> <p>-The PT result was indicated as high. *The report indicated it had been sent to the physician and the provider on 6/2/15. *There was no documentation on the report the above test results had been addressed.</p> <p>Review of resident 5's May and June 2015 MARs revealed: *He had been given warfarin 5 milligrams every bedtime from 5/26/15 through the present date. *The physician's order date had been 5/26/15. *The entry specified to recheck PT and INR in one week.</p> <p>Interview on 6/24/15 at 8:25 a.m. with LPN A regarding resident 5 revealed: *The 6/2/15 lab report for the PT and INR was the last time it had been done. *She had been unable to find physician's orders related to the 6/2/15 lab. *She reviewed the PT and INR log book at the nurse's station where they kept track of the labs. -She stated resident 5's sheet in the log book did not make sense. -It should have listed 6/2/15 as the date it was done, and if it was to have been done in one week then it should have been done on 6/9/15. *According to the log book the date of the last lab test appeared to be written as 6/25/15 and to recheck in one week on 6/30/15. -She agreed that could not have been accurate since it was not even 6/25/15 yet. *She thought it should have been done 6/9/15 but would follow-up.</p> <p>Further interview on 6/25/15 at 9:15 a.m. with LPN A revealed: *She still had not heard anything from the clinic on resident 5's PT and INR from 6/2/15.</p>	F 281		
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F 281	<p>Continued From page 24</p> <p>*They still did not have physician's orders to address the lab on 6/2/15.</p> <p>*She agreed it should have been addressed the same day it had been completed.</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim DON and the DON from another facility regarding resident 5 revealed:</p> <p>*They would have expected the lab results to have been followed up on within a day at least.</p> <p>*They agreed they should have had physician orders related to that lab.</p> <p>*They agreed there could have been a negative effect on the resident if the lab was abnormal.</p> <p>On 6/25/15 at 10:55 a.m. the DON from another facility brought another copy of the 6/2/15 PT and INR lab report for resident 5 for review. That report indicated to continue the same dose of medication and recheck the lab in two weeks. It had no documentation that it had been addressed by nursing.</p> <p>Interview on 6/25/15 at 11:10 a.m. with LPN A regarding the newer copy of resident 5's 6/2/15 lab results revealed:</p> <p>*The lab recheck still had not been done according to the physician's orders.</p> <p>*It should have been done during the prior week.</p> <p>*She would have the lab work done the following morning.</p> <p>Review of the provider's 1/6/15 Lab Processing/Tracking guideline policy revealed:</p> <p>**3. Document the physician notification in the resident's clinical record (progress notes).</p> <p>*4. Document the date of the physician notification on the diagnostic report itself...If the physician response in relation to the laboratory</p>	F 281		
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F 281	Continued From page 25 test results is not received by the end of the shift during which the results were communicated, the oncoming nurse must continue to attempt to contact the physician for follow up. *Continue these follow-up attempts until the physician responds and/or notify the Medical director if needed. *Document all follow-up attempts in the resident's clinical record. *5. Document the physician response to notification in the clinical record and any new orders received, if applicable." Surveyor: 35237	F 281		
F 309 SS=H	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure the physical, mental, and psychosocial needs were met for one of one sampled resident (1) during a change in condition by: *Notification of the physician and dietitian of a progressive and significant weight loss. *Following the dietitian's recommendations for weight loss. *The continued administration of a laxative with	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1A R1 not on blood glucose monitoring in facility before went to hospital on 6/4/15 and discharge instructions from hospital on 6/8 stated blood glucose as before R1 physician notified and had pre-albumin/albumin drawn and house supplement started and weekly weights being done R1 had stool obtained to check for C-Diff and it was negative and lactulose order changed R1 Behaviors are monitored for refusal of care R1 physician notified and order obtained to change abdominal wound treatment and wound is healed and all wounds being measured and documented weekly 1B R2 weight reviewed by IDT on 6/7 and weight being done weekly R3 weight reviewed by IDT on 6/7 and weight stable R7 weight reviewed by IDT on 6/7 and weight stable All residents have the potential to be affected.	

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F 309	<p>Continued From page 26 recurrent diarrhea. *Notification to the physician of no improvement for a mid-abdominal wound. *Not assessing blood sugars with her weight loss and poor intake to manage her diabetes mellitus (increased sugar in the blood). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *A 10/7/13 admission date. *Diagnoses of diabetes mellitus (abnormally high levels of glucose [sugar] in the blood) and hepatic encephalopathy (loss of brain function that occurs when the liver is unable to remove toxins [poisons] from the blood).</p> <p>Review of resident 1's 6/4/15 hospital history and physical revealed: *"She has had increasing and worsening confusion and inappropriate behavior." *"She is completely disoriented [confused] and is unable to make a coherent [logical] thought or sentence at this time." *"There is an area of slight skin breakdown in the mid-abdominal area above the navel [belly button]. This area is square in shape and erythematous [redness of skin that occurs with any skin injury, infection, or inflammation]. Nontender and there is no exudate [drainage]." *"Her weight status is unknown as to whether she gained or lost weight." *"Diabetes mellitus and is taking glipizide [blood sugar lowering medication]. I believe we have to be careful about hypoglycemia [low blood sugar] on glipizide." *"History of left hip joint infection postoperatively related to non-compliance."</p>	F 309	<p>2. All new orders are being reviewed for accuracy by DNS/designee daily IDT reviews weights on a weekly basis All residents reviewed and have weekly skin assessments Weekly wound assessment/tracking forms were started on resident's with pressure/wounds and are measured weekly Nurses will notify physicians of any changes in skin, weights, labs or changes in health status. Nurses inserviced on notification of physician in weight changes, wounds not improving, lab results and changes in health status timely and documented in the medical record.</p> <p>3. Dietary manager/designee will do random audits of five residents for completion of weekly weights and physician's notified of changes x 4 weeks then x2 per month x 2 months. QA will determine continued action to monitor compliance. DNS/designee will audit wound assessment/tracking sheets weekly for completion x 1 month, x2 per month x 1 month, then x1 per month x 1 month. QA will determine continued action to monitor compliance. DNS/designee will do random audits of 5 residents for completion of weekly skin assessment weekly x 4 weeks, x2 per month x 1 month, then x1 x 1 month. DNS/designee will do random audits of 5 residents weekly for physician notification of changes in weight, skin/wounds, lab or changes in health status weekly x 4, x2 x 1 month, then x 1 x 1 month. QA will determine continued action to monitor compliance. <i>* Don will report to QA monthly. DW/5000H/JJ</i></p> <p>4. Substantial compliance achieved</p>	7/17/15
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F 309	<p>Continued From page 27</p> <p>Review of resident 1's 6/8/15 hospital discharge instructions revealed:</p> <ul style="list-style-type: none"> *DuoDerm (moisture retaining wound dressing used for wounds with exudate). *Accuchecks (blood sugar test by a device) as before. *Had not been eating. Taking Glucerna (nutrition shakes to help minimize blood sugar spikes [ups and downs] and manages diabetes). "States will do better." *Resident admitted from nursing home with chronic left hip wound. *Coffee burn to mid-abdomen that was present on admission from nursing home. Area had scant yellow non-odorous drainage. <p>Review of resident 1's 1/9/15 through 6/23/15 Weights and Vitals Summary revealed the following weights:</p> <ul style="list-style-type: none"> *1/9/15- 301 pounds (lb). *1/26/15- 299 lb. *3/10/15- 290 lb. *3/30/15- 290 lb. *5/4/15- 271.5 lb. *5/31/15- 255 lb. *6/23/15- 247.5 lb. <p>Review of the above weights revealed resident 1 had:</p> <ul style="list-style-type: none"> *Lost 24 lb from 5/4/15 to 6/23/15, a 8.8 percent (%) loss. (A 5% weight loss in one month is significant and weight loss greater than 5% is severe.) *Lost 7.5 lb from 5/31/15 to 6/23/15, a 2.9% loss in three weeks. <p>Review of resident 1's 5/21/15 registered dietitian's (RD) progress notes revealed:</p> <ul style="list-style-type: none"> **She was hospitalized from 5/5/15 to 5/12/15 for 	F 309		
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F 309	<p>Continued From page 28</p> <p>sepsis [blood infection]."</p> <p>***She is not eating well. Current intake is 47% breakfast, 10% lunch, 1% supper, and 14% snack. She has lost weight as a result of her poor intake."</p> <p>***Current weight is 271.5 lb. She lost 18.5 lb since March 2015 and 29.5 lb in six months. She is baseline with her weight one year ago and a admission."</p> <p>***Total nutrition intake does not meet estimated needs."</p> <p>***Inadequate oral intake, inadequate protein intake, and unintentional weight loss."</p> <p>***Unplanned weight loss related to inadequate intake evidenced by 9.8% weight loss in six months and 29.5 lb."</p> <p>***She is morbidly [severely] obese even with weight loss."</p> <p>***She has several wounds."</p> <p>***Previously she was extremely non-compliant [would not follow] with her written meal plan and now she is just not eating."</p> <p>***RD will add enrichment to her meal plan and recommends 8 ounces of house supplement three times a day [TID]. She has refused this in the past along with Propass [powder protein supplement], but RD wants to try again."</p> <p>***RD will have certified dietary manager [CDM] fax this request to the physician for review."</p> <p>***Nutrition goals are weight stable and wound healing."</p> <p>Review of resident 1's dietary card and May 2015 through June 2015 medication administration records and treatment administration records revealed no documentation she had received the Propass powder or the house supplement TID.</p> <p>Review of resident 1's 6/8/15 through 6/23/15</p>	F 309		
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F 309	<p>Continued From page 29</p> <p>nursing progress notes revealed:</p> <p>*6/8/15- "Resident returned to facility from hospital. Has old wound with scab on right arm, abdomen reddened with DuoDerm dressing intact. Open wound on left hip with dressing in place."</p> <p>*6/9/15- "Resident complains of having diarrhea. Order received for stool to be checked for Clostridium Difficile [C-diff, infection spread easily that appears in residents taking antibiotics or hospitalized. Requires bleach to kill organism]."</p> <p>*6/13/15- "Wound on right arm remains, dry scab intact. Wound on abdomen noted to have moderate amount of dark blood pooling inside the old dressing. Wound measures 3.0 centimeter [cm] by 2.0 cm. Surrounding skin light pinkish in color. Scant bleeding still observed after wound was cleansed. DuoDerm applied as ordered."</p> <p>*6/14/15- "Polyethylene Glycol powder [stool softner] given for constipation."</p> <p>*6/15/15- "Has clear speech. Able to make her needs known and understands others. No delirium [altered level of memory]. She has shortness of breath with exertion and if laying flat in bed."</p> <p>*6/23/15- "Polyethylene Glycol powder given for constipation."</p> <p>Review of resident 1's June 2015 MAR and treatment administration record (TAR) revealed she had:</p> <p>*Received Glipizide daily for diabetes.</p> <p>*No documentation her blood sugars had been monitored.</p> <p>*No documentation her weekly weight had been done. There was documentation she had been hospitalized on 6/8/15, she had refused to be weighed on 6/15/15, and there was no weight documented for 6/23/15.</p>	F 309		
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F 309	<p>Continued From page 30</p> <p>*Received Polyethylene Glycol powder every day for constipation except when she had refused the medication on 6/15/15, 6/19/15, and 6/23/15.</p> <p>*DuoDerm dressing was changed daily on mid-abdominal wound with no documentation of the appearance of the wound.</p> <p>Review of resident 1's 6/9/15 through 6/24/15 bowel movement record revealed: *There was no documentation the stool ordered on 6/9/15 for C-diff had been obtained. *She had ten episodes of diarrhea. *Two of the diarrhea stools had been incontinent (loss of control).</p> <p>Review of resident 1's nurse's progress note to the physician revealed: **"Patient is alert." **"Patient states that she is having diarrhea-unable to eat/drink related to it." **"Patient has large sore to stomach-currently dressed and unable to assess."</p> <p>Review of resident 1's blood sugar monitoring record revealed no documentation her blood sugar had been checked since 1/8/14.</p> <p>Review of resident 1's 6/7/15 through 6/8/15 blood sugars in the hospital revealed they had been 61 milligrams/deciliter (mg/dl) to 89 mg/dl (normal 80 mg/dl to 100 mg/dl).</p> <p>Review of resident 1's 6/9/15 current physician's orders revealed: *Stool for C-diff 6/9/15. *Check vitals (blood pressure, pulse [heart rate], respirations [breaths per minute], and weight) weekly on Mondays. *DuoDerm to abdomen one time a day until</p>	F 309		
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F 309	<p>Continued From page 31 healed.</p> <ul style="list-style-type: none"> *Shower daily for dermatitis (skin irritation). *Weekly skin review one time a day every Saturday. *Glipzide 2.5 mg one time a day related to diabetes. *Glucagon 1.0 mg intramuscularly as needed (PRN) for low blood sugar. *Glucose gel one vial (tube) PRN for low blood sugar. *Polyethylene Glycol powder 17 grams one time a day for constipation. <p>Review of resident 1's 5/24/15 through 6/23/15 breakfast, lunch, and supper meal intake record revealed:</p> <ul style="list-style-type: none"> *Sixty-three meals with documentation "little to none" was consumed. *Fifteen meals 25% was documented as consumed. *Eight meals 50% was documented as consumed. *Three meals 75% was documented as consumed. *Five meals 100% was documented as consumed. <p>Review of resident 1's 6/1/15 through 6/23/15 bathing record revealed:</p> <ul style="list-style-type: none"> *There was documentation she received bathing assistance on 6/13/15, 6/17/15, and 6/20/15. *There was documentation for the remainder of the days "Activity did not occur. Resident did not receive bath/shower on this shift." <p>Review of resident 1's 6/1/15 through 6/23/15 eating assistance record revealed:</p> <ul style="list-style-type: none"> *Documentation "Resident did not eat or drink during this shift" for the 10:00 p.m. to 6:00 a.m. 	F 309		
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F 309	<p>Continued From page 32</p> <p>daily.</p> <p>*Documentation "Resident did not eat or drink during this shift" for the 6:00 a.m. to 2:00 p.m. for five days.</p> <p>*Documentation "Resident did not eat or drink during this shift" for the 2:00 p.m. to 10:00 p.m. shift for four days.</p> <p>Review of resident 1's 6/1/15 through 6/23/15 behavior log revealed documentation only on 6/14/15 and 6/23/15 she had resisted activities of daily living (ADL) assistance.</p> <p>Interview on 6/23/15 at 2:00 p.m. with the director of nursing (DON) regarding resident 1 revealed she:</p> <p>*Was a difficult resident with her behavior and her history.</p> <p>*Had chronic issues with her left hip.</p> <p>*Was often manipulative and refused to get out of bed, eat meals, or allow staff to assist her with her ADL. She was unsure why the staff had not documented her frequent resistance on the behavior log.</p> <p>*Was more alert since she had returned from the hospital on 6/8/15 after some of her medications had been adjusted.</p> <p>*Knew she had lost weight but had not realized it was 24 lb since May.</p> <p>*Confirmed they had not obtained the stool for C-diff as ordered by the physician on 6/9/15 and was unsure why.</p> <p>*Knew they had not notified the dietitian of her continued weight loss since the dietitian had just assessed her 5/21/15.</p> <p>*Felt it had been the dietary manager's responsibility to get the orders for the nutritional supplement from the physician was and that was why nursing had not followed through on the</p>	F 309		
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F 309	<p>Continued From page 33 recommendations.</p> <p>Phone interview on 6/25/15 at 8:30 a.m. with the consultant dietitian regarding resident 1 revealed she:</p> <ul style="list-style-type: none"> *Had not been informed that the resident had been in the hospital from 6/4/15 through 6/8/15. *Did not usually find out when a resident was in the hospital or when they returned until she did her monthly visits. *Had told the DON or the dietary manager to let her know about residents' hospitalizations and readmissions or changes in residents' conditions. *Tried to check on the resident or do an assessment within forty-eight hours after returning to the facility. *Had not been informed of her weight loss from 271.5 to 247.5 lb. *Was not aware they had not been following her 5/21/15 recommendation for house supplement TID. *Had informed the dietary manager of her recommendations. The usual dietary manager was on a medical leave, but she had informed the dietary manager that was filling in for her from another facility. <p>Interview with resident 1 on 6/25/15 at 9:15 a.m. revealed she:</p> <ul style="list-style-type: none"> *Obtained the wound on her abdomen from spilling hot coffee on her lap. *Obtained the wound prior to her hospitalization on 6/4/15. She remembered the staff helping her with her wet shirt. *Had quite a bit of discomfort from the wound on her abdomen, especially when they were changing the dressing. *Knew the wound bled almost every time they changed her dressing, and there was a foul and 	F 309		
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F 309	<p>Continued From page 34 rotten odor to it.</p> <p>Observation on 6/25/15 at 9:30 a.m. of resident 1's abdominal wound revealed: *Licensed practical nurse (LPN) J removed the old DuoDerm dressing from the wound. *The area around the DuoDerm dressing was light red. *The wound measured 2.8 cm by 5.0 cm. *There was a moderate amount of yellow drainage. *There was no odor.</p> <p>Interview at that time with LPN J regarding resident 1's abdominal wound revealed she: *Thought it had gotten worse since she had returned from the hospital. *Was unsure how she had obtained the area as she had started the end of April 2015. *Was going to send a note along to the wound clinic today to have them look at her abdominal wound when they checked the area on her right arm wound. *Was not sure why the physician had not been updated before today the DuoDerm dressing was irritating her skin, and the wound was not improving. *Was not sure regarding how often documentation should have been done regarding wounds that were not pressure ulcers.</p> <p>Review of resident 1's 6/25/15 physician's report revealed: *Documentation sent from LPN J: -"Has a old burn area on abdomen that measures 2.8 cm by 5.0 cm red area with a center area 1.3 cm by 3.0 cm scabbed area with yellowish drainage." -"Current treatment is change daily with</p>	F 309		
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F 309	<p>Continued From page 35 DuoDerm." *Documentation sent from the physician: -"Cleanse area on anterior abdominal wound daily with normal saline." -"Apply Silvadene cream [prevent and treat infections of second and third degree burns] and cover with Meplix Border [all-in-one foam dressing to minimize patient pain and trauma to wound and surrounding skin]." -"Return appointment 7/2/15."</p> <p>Interview on 6/25/15 at 11:00 a.m. with the interim director of nursing and a DON from another facility regarding resident 1 revealed: *They felt the burn area on her abdomen had occurred in the hospital. *There was no documentation in her medical record it had occurred before her 6/4/15 hospitalization. *They did not agree with the hospital discharge summary it had occurred in the facility nor did they think the resident would have known due to her delirium prior to her hospitalization. *They agreed the staff did not assess her abdominal wound on 6/8/15 as it was covered with a DuoDerm dressing. The staff measured the area on 6/13/15. There was no further documentation regarding the size of the area or drainage until this a.m. when the surveyor asked LPN J to measure the area. *They had not changed the DuoDerm treatment as that was what the hospital had told them to use. They had not ever seen DuoDerm used for burns and effective for healing. *They felt the physician had been kept updated of her weight loss.</p> <p>Review of the package insert for the DuoDerm dressing revealed:</p>	F 309		
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F 309	<p>Continued From page 36</p> <p>**Designed to reduce the risk of further skin breakdown due to friction."</p> <p>**DuoDerm dressing can be used for dry to lightly exuding [draining] wounds."</p> <p>**It can be used to manage stage I and stage II pressure ulcers [sores]."</p> <p>**The dressing can be removed without damaging newly formed tissue."</p> <p>**It is designed to reduce the risk of further skin breakdown due to friction by preventing contact with clothes/bed linen."</p> <p>**It can be used on skin tears and superficial [just below the surface of the skin] wounds, dry to lightly exuding wounds, and newly-formed tissue or skin at risk for further breakdown."</p> <p>**The translucent [allowing light to pass through] backing enhances dressing placement and initial monitoring of the wound."</p> <p>Review of the provider's 2/3/15 Weight Monitoring policy revealed:</p> <p>**When weight change is significant or severe, the licensed nurse will notify the patient's [resident's] physician, and obtain and carry out treatment orders if given."</p> <p>**The licensed nurse will also notify the patient's family member or legal representative."</p> <p>**Additionally, the living center will notify the dietitian."</p> <p>**Each living center will have a nutrition risk committee. This committee should meet regularly to determine possible reasons for weight loss or gains and to make recommendations to prevent further unplanned changes."</p> <p>Review of the provider's 5/1/15 Weekly Skin Review policy revealed:</p> <p>**The accuracy and thoroughness of the weekly skin review will assist in timely identification of</p>	F 309			

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F 309	<p>Continued From page 37</p> <p>skin at risk and initiation of a plan of care." ***The licensed nurse will complete a head-to-toe skin review." ***If an alteration [change] is identified-dry, rash, redness, skin tear, blisters, or other, the nurse is to indicate the sites and describe the type and location." ***If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow Sheet, one flow sheet for each alteration identified." ***Care plans are to be updated with new interventions, and certified nursing assistant care sheets as indicated."</p> <p>Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed: ***To ensure that proper notifications are made when a resident has a change in health status." ***The center will consult the resident's physician a need to alter treatment significantly due to adverse consequences, or to commence [start] a new form of treatment." ***Notification is dependent on the nursing assessment and may be immediate to forty-eight hours." ***Nursing judgement is an integral [whole] part of the skilled care provided in the living center. Judgement must be applied in a case by case basis in keeping with acceptable nursing practice."</p> <p>Review of the provider's 1/6/15 Laboratory Processing/Tracking Guideline policy revealed: ***To ensure that diagnostic tests are processed, ordered, obtained, performed, and results received timely." ***Test results are communicated to the physician</p>	F 309		
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F 309	<p>Continued From page 38</p> <p>in a timely manner with documentation present in the medical record." *"Labs [laboratory blood tests] are scheduled and drawn per physicians' orders."</p> <p>Surveyor: 32572</p> <p>B. Based on record review, interview, and policy review, the provider failed to notify the physician with weight changes for three of nine residents (2, 3, and 7). Findings include:</p> <p>1. Review of resident 2's weight record revealed: *1/2/15-171 pounds (lb). *1/6/15-164 lb. *1/13/15-161 lb. *2/24/15-161 lb. *3/3/15-155 lb.</p> <p>2. Review of resident 3's weight record revealed: *1/30/15-151 lb. *1/20/15-154 lb. *1/27/15-152 lb. *2/3/15-156 lb. *2/6/15-155 lb. *2/10/15-152 lb. *2/24/15-157 lb. *3/20/15-155 lb. *3/24/15-151 lb. *4/7/15-153 lb. *4/14/15-148 lb. *4/21/15-151 lb. *4/28/15-147 lb.</p> <p>3. Review of resident 7's weight record revealed: *1/21/15-168 lb. *2/4/15-162 lbs. *2/11/15-167 lbs. *4/29/15-169 lbs. *5/6/15-141 lbs.</p>	F 309		
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F 309	<p>Continued From page 39</p> <p>*5/13/15-163 lbs. *5/27/15-148 lbs. *6/3/15-167 lbs.</p> <p>4. Review of resident 2, 3, and 7's interdisciplinary progress notes revealed no documentation from the dietary manager, dietician, or nurses regarding weight changes or physician notification.</p> <p>Review of the provider's 2/12/15 reviewed Weight Monitoring policy revealed: *"Electronic weight-monitoring: -The electronic weight-monitoring program is a tool used to review all weights for significant change and trends. Weights should be entered and monitored through the software identified by Golden Living." The policy did not indicate when a re-weighing of the resident should occur.</p> <p>Interview on 6/25/15 at 1:07 a.m. with the interim director of nursing confirmed she would have expected physician notification with a five pound weight change. She would have expected the resident to have been re-weighed and dietary staff notified of the weight changes.</p>	F 309		
F 323 SS=H	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323	<p>F323 – FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>1a. WanderGuard placed on resident 7's belt loop. Front door was locked on 6/23/15. As of 7/15/15 all WanderGuards have been removed per physician order. All residents have potential to be effected by this process.</p> <p>1b. Spray bottles are labeled with legible and specific label. Chemicals stored out of the access to all residents. All residents have potential to be effected by this process.</p>	

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F 323	<p>Continued From page 40</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 A. Based on observation, interview, record review, and policy review, the provider failed to ensure: *A safe environment for one of four sampled resident (7) who had been identified as an elopement risk and had eloped. *A system was in place to monitor the Wanderguard (resident monitoring system) bracelets for four of four sampled residents (1, 4, 7, and 12). Findings include:</p> <p>1. Observations of the front door not alarmed revealed: *6/23/15 and 6/24/15 at 7:45 a.m. *6/23/15 and 6/24/15 at 11:30 a.m. *6/23/15 at 5:30 p.m. *These were the busy times with residents going out the front door with no staff members present. *Along with random times on 6/23/15 and the a.m. of 6/24/15. The offices next to the door had not been occupied at all times to monitor those doors for resident elopement (leaving facility without staff knowing). The provider had residents who were at risk for elopement.</p> <p>2. Review of resident 7's medical record revealed: *He had been admitted on 1/16/13. *His diagnoses included: -Vascular dementia (diminished thought processes caused by decreased blood flow in the brain) with delusions (a false belief about himself).</p>	F 323	<p>2a. Nursing staff educated on proper procedure for checking placement and function of WanderGuards. Nursing staff educated on proper computerized order entry to ensure eMAR gives notice for placement and function check per physician order and/or manufacturer guidelines. All staff educated prior to working a shift on Elopement Guideline. Audit of all residents wearing a WanderGuard on 6/24/15 to ensure placement, function, and proper eMAR entry.</p> <p>2b. Automatic locking door handles installed on north and west tub room and soiled utility room on 7/10/15. All staff educated on the proper storage of chemicals and locking of doors to ensure no resident has access.</p> <p>3a. Director of Nursing or designee will perform audits of all residents wearing a WanderGuard to ensure placement, function, and proper eMAR charting. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Director of Nursing to monthly QAPI committee for review and recommendation.</p> <p>3b. Administrator or designee will perform audits of north and west tub room and soiled utility room to ensure chemicals are properly stored and locked. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation.</p> <p>4a. Substantial compliance achieved</p> <p>4b. Substantial compliance achieved</p>	<p>7/17/15</p> <p>* awlsam/HJ</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
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F 323	<p>Continued From page 41</p> <ul style="list-style-type: none"> -Anxiety (nervousness). -Depression (down mood). *He had been identified as an elopement risk on the 1/16/13 initial assessment. *He had eloped from the facility on 4/1/15. -He had been a block away from the facility. -A staff member returning to work found the resident. -A Wanderguard bracelet had been applied that day when he returned to the facility. <p>Review of the 3/20/15 through 3/21/15 Quarterly Interdisciplinary Resident Review assessment revealed:</p> <ul style="list-style-type: none"> *It had been completed prior to the elopement on 4/1/15. *The resident had: <ul style="list-style-type: none"> -"History of wandering. 5/2014 used to wear wanderguard." -"Short term and long term memory problem." *Questions for the Risk for Elopement section completed within that assessment revealed: <ul style="list-style-type: none"> -"Is the resident physically able to leave the building on their own? Yes." -"Is the resident cognitively [thinking memory, or reasoning] impaired? Yes." -"Does the resident have impaired decision making skills? Yes." -"Is there a history of wandering or elopement? If yes, implement Elopement IPOC (immediate plan of care). Yes." -"Wanders aimlessly about the facility and/or exhibits night wandering?" Hand written in was "Sometimes gets mixed up to what time it is." <p>Review of resident 7's quarterly 3/27/15 MDS (Minimum Data Set) revealed a Brief Interview for Memory Score (BIMS) [testing of thought processes] revealed a BIMS score indicating an</p>	F 323		
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F 323	<p>Continued From page 42 intact (okay) memory.</p> <p>Review of resident 7's interdisciplinary progress notes revealed the following statements about the Wanderguard bracelet: *6/19/15 at 9:08 a.m. "Resident refuses to wear and will not leave in pocket." *6/19/15 at 8:26 p.m. "Bracelet off." *6/21/15 at 9:44 a.m. "Refuses to wear." *6/21/15 at 8:07 p.m. "Wanderguard in medroom." *6/22/15 at 7:17 p.m. "Wanderguard in medroom. Refused to put it on." *6/23/15 at 9:08 a.m. "Wanderguard in medroom. Refused to put on."</p> <p>Review of resident 7's Physician Order Summary printed on 6/24/15 at 1:22 p.m. revealed a physician's order to "Check wanderguard device twice daily at 1000 [10:00 a.m.] and 2000 [8:00 p.m.] for history of wandering and elopement related to vascular dementia [forgetfulness due to blood flow problems] with delusions."</p> <p>Review of resident 7's care plans revealed: *There had been a printed care plan in a three ring binder notebook at the nurses station. *There had been a different care plan in the computer. *The provider had given the surveyor a copy of the care plan that had been in the three ring binder notebook at the nurses station. -That care plan stated "Resident refuses to wear wanderguard." *The care plan in the computer stated "Resident refuses to wear wanderguard. 4/1/15 wanderguard placed after elopement. Order entered to check placement of wanderguard twice daily."</p>	F 323		
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F 323	<p>Continued From page 43</p> <p>Review of resident 7's activity log revealed for April through June 2015 revealed: *April he attended devotions twelve times. *May he attended devotions nine times and an entertainment program once. *June he had attended devotions five times.</p> <p>Surveyor: 35237 Interview on 6/24/15 at 3:30 p.m. with certified nursing assistant (CNA) N revealed: *She had been working in the facility for about a week. *She knew resident 7 had been an elopement risk. *She further stated she had seen resident 7: -Go out the main entrance door last week sometime. -The nurse brought him back in the building right away. -The alarm had not sounded when he went out the door.</p> <p>Surveyor: 32572 Review of resident 7's behavior log dated 3/15/15 through 6/24/15 revealed: *Two entries the resident "screamed at staff." *All other entries were "None of these behaviors apply." *There had been no entry on 4/1/15 about the resident's elopement or wandering. *There had been no entry regarding wandering or elopement from 6/13/15 through 6/22/16.</p> <p>Interview on 6/24/15 at 12:00 noon with administrator and interim director of nursing (DON) and the DON from another facility regarding resident 7 confirmed: *The care plans had conflicting information.</p>	F 323		

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F 323	<p>Continued From page 44</p> <ul style="list-style-type: none"> *The care plan in the computer was the most current. *The resident did not have a Wanderguard in place. -The resident would remove the Wanderguard. *They were unable to determine how the resident removed the Wanderguard from his wrist. *They had attempted placing the Wanderguard in his pocket. -The resident would no longer allow the Wanderguard to be placed in his pocket. -There had been no other interventions attempted for the Wanderguard placement. <p>3. A wanderguard audit that had been completed on 6/24/15 revealed:</p> <ul style="list-style-type: none"> *Resident 1's Wanderguard to be functioning. A new elopement risk assessment had been completed and determined the resident was not at risk for elopement. The Wanderguard had been removed. *Resident 4's Wanderguard was functioning. *Resident 7's Wanderguard was not functioning. A Wanderguard had been applied to his belt. *Resident 12's Wanderguard was functioning. <p>Review of the provider's report sheet revealed residents 4, 7, and 12 had Wanderguards. There was no documentation for resident 1 having a Wanderguard.</p> <p>Interview on 6/24/15 at 12:00 noon with the administrator and interim DON and the DON from another facility confirmed:</p> <ul style="list-style-type: none"> *Review of resident 1, 4, 7, and 12's physicians' orders confirmed orders to check Wanderguard device functioning twice daily. *They confirmed the physicians' orders to check the Wanderguard had been entered into the 	F 323		
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F 323	<p>Continued From page 45</p> <p>computer inaccurately for residents 1, 4, and 12.</p> <p>-There had been no documentation of the functioning of the Wanderguards on the medication administration record (MAR) or treatment administration record (TAR).</p> <p>*Resident 7's June 2015 MAR indicated the resident had:</p> <p>-Refused three of those forty-seven times documented the device had been checked.</p> <p>-Stated see the nurses notes twelve of those forty-seven times documented the device had been checked.</p> <p>*All staff members should have been aware of residents who were at risk for elopement.</p> <p>-There was no list of residents with Wanderguards.</p> <p>Recieved on 6/24/15 at 1:20 p.m. from the executive director the following information:</p> <p>*A copy of the notebook that was kept at the nurses station with information about which residents had Wanderguards. That notebook did not include resident 1's information.</p> <p>*A copy of the Facility Orientation Checklist that each new employee recieved upon being hired. Included in that was location of door alarms/Wanderguard alarms.</p> <p>*A training form regarding prevention of elopement included:</p> <p>-"Residents at risk for elopement wear identification bracelets."</p> <p>-"Exits must be under visual superision by designated associates."</p> <p>-That form was signed with acknowledgment of training by the employee and facilitator (educator).</p> <p>Review of the provider's undated Elopement Guideline policy revealed:</p>	F 323		

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F 323	<p>Continued From page 46</p> <p>*The definition for elopement was a "Situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs and therefore at risk for injury outside the confines of the living center, has left the living center without knowledge of staff."</p> <p>*The ongoing review of residents would occur quarterly and as needed.</p> <p>*The prevention statement stated: -Staff would: --"Observe that each resident's bracelet alarm/device is still in place each shift." --"Establish a process to check bracelet alarm/device batteries according to manufactures directions" -"Document findings on the TAR or other form of documentation." *Door alarms and resident protection alarms -A "roster of bracelet battery expiration dates and replace prior to expiration date." --The provider did not have this roster. -"The charge nurse or designee shall test resident personal alarms/devices according to manufacturer's recommendation." *Quality assurance process improvement (QAPI) monitoring revealed "All elopement events will be reviewed, analyzed, and summarized by the LC [living center] QAPI committee to ensure the appropriate process improvement actions have been taken." *Monitoring compliance: -"The following elements are in place for the living center to demonstrate satisfactory compliance with the guide: --All residents identified 'at risk' have a picture in the elopement book. --Care plan for elopement in place and interventions individualized and implement per physical observation.</p>	F 323		
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F 323	<p>Continued From page 47</p> <p>--Staff able to verbalize knowledge of elopement procedure.</p> <p>--Door alarms are checked and documented in building engines [documentation computerized program].</p> <p>--Alarm bracelet function is checked daily and documented."</p> <p>Surveyor: 35237</p> <p>B. Based on observation, interview, manufacturer's label review, material safety data sheet (MSDS) review, and policy review, the provider failed to ensure chemicals had been secure and were not accessible to residents for:</p> <p>*One of two tub rooms (North wing).</p> <p>*One of one soiled utility room.</p> <p>Findings include:</p> <p>1. Observation on 6/23/15 at 7:50 a.m. during the initial tour and again at 4:00 p.m. revealed:</p> <p>*The North hallway tub room door was unlocked and open. A spray bottle with yellow liquid had been sitting on a plastic wheeled cart near the tub. The label was worn and unreadable.</p> <p>*Residents had access to and had been observed near the above area. There were cognitively (thinking process) impaired residents in the facility that could have entered the above area.</p> <p>Interview on 6/23/15 at 7:50 a.m. with certified nursing assistant (CNA) E revealed:</p> <p>*The unlabeled spray bottle had been whirlpool disinfectant cleaner.</p> <p>*She stated it was filled from a bigger bottle</p> <p>*The bigger bottle was locked in the storage area of the tub</p> <p>-It was labeled Classic Whirlpool Disinfectant Cleaner and had warnings including:</p>	F 323			

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F 323	<p>Continued From page 48</p> <ul style="list-style-type: none"> -Hazard to humans and domestic animals. -Do not get in eyes, on skin, or on clothing. -Harmful if swallowed. <p>*She agreed it should have had a label that was readable.</p> <p>2. Observation on 6/24/15 at 10:35 a.m. of the soiled utility room revealed:</p> <ul style="list-style-type: none"> *The door had been unlocked. *One spray bottle that was three-fourths full of purple liquid was on the counter. The bottle was labeled QC A-456-II. -That label had warnings including: <ul style="list-style-type: none"> -Hazard to humans and domestic animals. -Causes moderate eye irritation. -Avoid contact with eyes or clothing. *One spray bottle that was approximately one-eighth full of purple liquid on the counter. -That bottle had a sticky note taped to the side stating it was for wheelchairs. <p>Observation and interview on 6/24/15 at 2:45 p.m. with the housekeeping and laundry supervisor regarding the soiled utility room revealed:</p> <ul style="list-style-type: none"> *The door had been unlocked. *The same bottles as during the above observation had been on the counter. *He stated those had been used for wheelchair cleaning by the nursing staff. *Both bottles contained A-456-II disinfectant. *He agreed the disinfectants had been out on the counter, and the unlocked door had not been secure from residents. *He agreed residents could have been at risk for injury. <p>Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and the DON from</p>	F 323		

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F 323	<p>Continued From page 49</p> <p>another facility revealed the disinfectants could have been a risk to the residents.</p> <p>Review of the MSDS sheet for the Classic Whirlpool Disinfectant Cleaner revealed: *It had a hazard rating of moderate. *Health hazards included: -Would cause eye irritation and skin irritation with prolonged exposure. -Could be harmful if swallowed or if spray mist was inhaled. *Handling and storage included: -Do not reuse empty containers. -Keep out of reach of children.</p> <p>Review of the MSDS sheet for the A-456-II Disinfectant Cleaner revealed: *Hazard statements included: -Harmful if contact with skin. -Causes eye irritation. *Handling and storage included: -Keep out of reach of children. -Keep container tightly closed. -Store in suitable labeled containers. *Disposal considerations included "Do not reuse empty containers."</p> <p>Review of the provider's 12/1/14 Cleaning and Disinfecting Non-Critical Resident-Care Items policy revealed: *"Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including: -c. Storage; -e. Safe use and disposal."</p>	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPAIRE/SERVE - SANITARY	F 371	F371 - FOOD PROCURE, STORE/PREPAIRE/SERVE - SANITARY	

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F 371	<p>Continued From page 50</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, interview, and policy review, the provider failed to ensure: *Sanitary (cleanliness) conditions were maintained in one of one kitchen area and one of one kitchenette area in the dining room. *Follow their policy for cleaning of the kitchen area. *Follow their policy for leftover food and the storage of food. Findings include:</p> <p>1. Observation on 6/23/15 at 7:45 a.m. of the kitchen area revealed: *Twenty-four bowls of uncovered and undated fruit cocktail in the refrigerator. *Five bowls of uncovered and undated crushed pineapple in the refrigerator. *Two bowls of uncovered and undated crushed jello in the refrigerator. *Two fruit snack cups labeled for random residents dated 6/15/15. *A scoop in the sugar canister. *An open purse sitting on the bottom shelf of a metal cart. The purse was sitting next to multiple baking supplies. There was a pair of shoes sitting</p>	F 371	<p>1a. All undated food in the refrigerator removed. All scoops removed from any storage container. Open pop bottle and hairbrush removed from kitchenette. Microwave cart and kitchenette stove top cleaned. All residents have potential to be effected by this process.</p> <p>1b. Applesauce on med carts within usage policy. All residents have potential to be effected by this process.</p> <p>1c. All staff was educated on proper food serving and hand washing procedure. All residents have potential to be effected by this process.</p> <p>2a. Dietary staff educated on 7/15/15 proper policy and procedure storing prepared foods policy and cleaning schedule policy.</p> <p>2b. Dietary and nursing staff educated on 7/15/15 proper policy of prepared food policy.</p> <p>2c. All staff was educated on proper food serving and hand washing procedure.</p> <p>3a. Dietary manager or designee will perform audits of undated food in the refrigerator, no scoops in storage containers and kitchen and kitchenette cleanliness. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Dietary Manager to monthly QAPI committee for review and recommendation.</p> <p>3b. Dietary manager or designee will perform audits of outdated applesauce on med carts. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Dietary Manager to monthly QAPI committee for review and recommendation.</p> <p>3c. Dietary manager or designee will perform audits of food service. Audits will be completed weekly proper serving and utensil handling techniques. DW SARAH TJJ</p>	
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F 371	<p>Continued From page 51 on the floor beside the cart. *A three tier metal cart the microwave was sitting on. The three drawers of the cart were sticky with dried food residue on the outside of the drawers. There was a tray that contained condiments (salt, pepper, and spices) that was sticky and covered with dried food spills. *A white coffee cup in a large canister that contained flour. The outside of the canister was sticky and had multiple dried food spills on it. *The outside of all the cupboards were sticky and had multiple dried food stains on them. *The fan in the dishroom was covered with dust.</p> <p>Observation on 6/23/15 at 8:00 a.m. of the kitchenette in the dining room revealed: *An open bottle of Mountain Dew pop in a cupboard. *An unmarked hairbrush in a drawer. *The top of a non-operating stove was covered with a white board that was covered with sticky food residue. The top of the stove under the board was covered with dried yellow food.</p> <p>Interview on 6/23/15 at 8:15 a.m. with cook O and dietary aide M regarding the above revealed: *The dietary manager had been on medical leave since June 1, 2015. *Another dietary manager from another facility filled in three to four days a week. She primarily did the schedule and did the ordering of food and supplies. *They were unable to find the book that contained the cleaning schedule for the kitchen.</p> <p>Interview on 6/23/15 at 11:15 a.m. with the business manager regarding the kitchen revealed: *She had been the dietary manager until a year</p>	F 371	<p>for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Dietary Manager to monthly QAPI committee for review and recommendation</p> <p>4a. Substantial compliance achieved</p> <p>4b. Substantial compliance achieved</p>	<p>7/17/15</p> <p>* [Redacted]</p> <p>DW/SOON/JS</p>
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F 371	<p>Continued From page 52 ago when she had taken the business manager position. *She knew their leftover food policy was three days, and then it should be disposed of. *She was unsure why all the undated and uncovered food was in the refrigerator. *Located the book that contained the cleaning schedule for the kitchen. The last documentation of any cleaning in the kitchen had been dated 5/12/15. *Revealed the dietary manager that had been filling in was out of town and was unable to visit with the surveyors.</p> <p>Phone interview on 6/25/15 at 8:30 a.m. with the dietitian regarding the kitchen revealed: *She was unaware of the unsanitary conditions in the kitchen. *They should have been following their policies for cleaning of the kitchen, the storage of food, and for leftover food.</p> <p>Review of the provider's undated Storing Prepared Foods policy revealed: **"Food or potentially hazardous food ingredients not stored in the original containers must be: -Stored in a method to maintain proper temperature and avoid cross-contamination. -Discarded if not used within use by date." **"The director of dining or designee must ensure that all food is properly stored, used, or disposed of according to guidelines." **"Extra portions are stored in shallow, loosely covered and approved containers in the refrigerator. Items are labeled with product name and use by date and placed in the refrigerator."</p> <p>Review of the provider's 2/3/15 Cleaning Schedules policy revealed:</p>	F 371		
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F 371	<p>Continued From page 53</p> <p>"An effective cleaning schedule must be developed and posted for each piece of equipment and all areas that require routine cleaning in the dining services department. The cleaning schedule includes item, frequency, and position accountable for the cleaning process."</p> <p>"The director of dining must develop, post, and enforce the cleaning schedules and monitor the completion of assigned cleaning tasks to ensure a sanitary environment."</p> <p>"The director of dining also takes appropriate action for items not cleaned per schedule."</p> <p>"The weekly schedule is posted in the dining services department. Dining service employees should complete cleaning assignments, and the director of dining should monitor compliance."</p> <p>"Splashes and spills should be wiped off surfaces as soon as they occur."</p> <p>Surveyor: 32572</p> <p>2. Random observations from 6/23/15 through 6/25/15 revealed applesauce on two of two nurses medication carts dates 6/19/15 written on a piece of tape and adhered to the lids.</p> <p>Interview on 6/24/15 at 8:40 a.m. with licensed practical nurse (LPN) A confirmed that was the date the applesauce was obtained from the dietary department.</p> <p>Interview on 6/25/15 at 11:07 a.m. with the interim director of nursing confirmed she would expect the applesauce to have been used within three days and then disposed of.</p> <p>Surveyor: 35237</p> <p>3. Observation on 6/23/15 from 11:45 a.m. through 12:15 p.m. of the residents and staff in</p>	F 371		
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F 371	<p>Continued From page 54</p> <p>the dining room revealed:</p> <ul style="list-style-type: none"> *Five unidentified female staff served food and drinks on plastic trays from the kitchen to the residents at the tables. *All of them touched the tops of the drink glasses while serving. *One staff member washed her hands, adjusted her shirt, proceeded to the kitchen, and then served the next resident's tray. *One staff member put her hands in her pocket then proceeded to serve the next resident's tray. <p>Observation on 6/23/15 from 5:45 p.m. through 6:00 p.m. of the residents and staff in the dining room revealed:</p> <ul style="list-style-type: none"> *Four unidentified female staff served food and drinks on plastic trays from the kitchen to the residents at the tables. *All of them touched the tops of the drink glasses and dessert bowls while serving. <p>Interview on 6/24/15 at 3:40 p.m. of the activity coordinator regarding the dining room observations revealed:</p> <ul style="list-style-type: none"> *She had served food and drinks during the above observations. *She had also been trained as a CNA. *She agreed the tops of the drink glasses should not have been touched during serving. *Nothing should have been touched that could have contacted the resident's mouth. <p>Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and the DON from another facility regarding the dining room observations confirmed the tops of the drink glasses should not have been touched during serving.</p>	F 371		
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F 371	Continued From page 55 Review of the provider's 2011 Nursing Responsibilities at Meal Service policy revealed "Staff from the Nursing and Dining Services departments work cooperatively to ensure that each patient has a pleasant dining experience and is served according to regulations."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure medications were not used beyond the expiration date in one of one medication room. Findings include:	F 425	F425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES RPH 1. Outdated and expired medications were immediately removed from the refrigerator and med carts. All residents have the potential to be affected. 2. Medication carts and refrigerator are being checked every week by the night nurse for expired and outdated medications. Nurses inserviced on dating inhalers, vials, etc when opened and checking for the expiration before administering the medication. 3. DNS/designee with audit the medication carts and refrigerator for expired medications weekly x 4, x2 for one month and then x1 monthly x 1 month. QA committee to determine continued action and monitor compliance. * Don will report to G-A monthly. OWSOAK/JJ 4. Substantial compliance achieved	7/17/15

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F 425	<p>Continued From page 56</p> <p>1. Observation and interview on 6/24/15 at 8:40 a.m. with licensed practical nurse (LPN) A of the refrigerator in the medication room revealed the following medications were either expired or outdated: *One multi-use vial of tuberculin with an opened date of 4/9/15. -She confirmed that vial was good for thirty days after opening thus it was an expired medication. *One Ziploc bag with four vials of Hepatitis B vaccine an expiration date of 1/25/15 printed on the manufacturer's medication label. *One Ziploc bag with one vial of Hepatitis B vaccine with a 9/8/14 expiration date printed on the manufacturer's medication label. -She confirmed those vials were expired and were from a pharmacy the provider has not used in over a year. She confirmed nursing had been responsible for monitoing medication expiration dates in the medication room.</p> <p>Review of the provider's undated Medication Administration policy revealed no directions about expired medications.</p> <p>Interview on 6/25/15 with the interim director of nursing (DON) confirmed those medications had expired and should have been disposed of prior to this date.</p> <p>Review of the Center for Disease Control and Prevention website at http://www.cdc.gov/injectionsafety/provider_faqs_multivials.html accessed on 6/30/15 revealed: **If a multi-dose vial has been opened or accessed (needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that</p>	F 425		
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F 425	Continued From page 57 opened vial." **If a multi-dose vial has not been opened or accessed, it should have been discarded according to the manufacturer's expiration date." **The manufacturer's expiration date refers to the date after which an unopened multi-dose vial should not be used."	F 425			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441 - INFECTION CONTROL, PREVENT SPREAD, LINENS 1a. DNS is the infection control officer for the facility. Tracking and trending of infections completed for the month of June and will be completed monthly. All residents have the potential to be affected. 1b. Posted manufacturers cleaning instructions in the each tub room. Both whirlpool tubs were disinfected per manufacturers instructions. All residents have potential to be effected by this process. 1c. Personal items are no longer stored comingled in the tub room. All residents have potential to be effected by this process. 1d. All hallway and resident room fans were cleaned on 7/6/15. All residents have potential to be effected by this process. 1e. Hydrocollator was cleaned on by 6/25/15. All residents have potential to be effected by this process. 1f. Wheelchair cushions in the soiled utility room were cleaned and put in the storage room. All residents have potential to be effected by this process. 2a. Infection control committee will meet monthly to review infections and make recommendations for		

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F 441	<p>Continued From page 58 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, manufacturer's instruction review, services agreement review, and policy review, the provider failed to ensure: *An infection control program had been implemented to collect, document, analyze, and investigate the data related to infections. *Appropriate disinfection of two of two whirlpool tubs (North and West wings) by two of two bath aides (D and E). *Resident care items had been stored appropriately in two of two tub rooms (North and West wings). *Three of six fans in the hallways (North and West wings) and two of two fans in resident's rooms (5 and 13) had been cleaned routinely. *One of one hydrocollator (unit for heating hot packs) machine in the physical therapy (PT) room had been cleaned routinely. *Two of two wheelchair cushions in the soiled utility room had been kept clean and sanitary. Findings include:</p> <p>1. Interview on 6/23/15 at 5:15 p.m. with the director of nursing (DON), administrator, and interim DON revealed: *All infection control policies and procedures</p>	F 441	<p>interventions/staff education. All staff educated on infection control policy and procedure.</p> <p>2b. All nursing staff educated on 7/15/15 for proper tub cleaning procedure.</p> <p>2c. All nursing staff educated on Disinfection of Non-Critical Resident-Care Items.</p> <p>2d. Maintenance Supervisor added cleaning all fans to preventive maintenance schedule for the 6th of each month.</p> <p>2e. Therapy department was educated on their hydrocollator cleaning policy. Hydrocollator will be stored unplugged when not in use. When Hydrocollator is in use, the cleaning policy will be followed.</p> <p>2f. Certified Nursing Assistant staff educated on Disinfection of Non-Critical Resident-Care Items.</p> <p>3a. Administrator will audit infection control tracking and trending monthly x 3 months for completion.</p> <p>3b. Administrator or designee will perform audits of tub cleanings. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation.</p> <p>3c. Administrator or designee will perform audits of personal items in the tub room. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation.</p> <p>3d. Maintenance Supervisor or designee will perform audits of the fans. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Maintenance Supervisor to monthly QAPI committee for review and recommendation.</p>	
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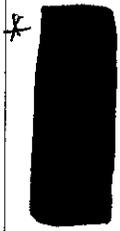
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F 441	<p>Continued From page 59 would have been online. *There was no specific infection control nurse. *They had not tracked specific types of infections. *They were unsure of how they would know if a specific type of infection had been increased from one month to the next if they had not tracked them other than through the nursing report. *They had not tracked which infections had been facility acquired versus hospital or community acquired. *They had not tracked specific types of organisms (germs or bacteria) related to infections. -The DON stated she thought they had minimal antibiotic use in the facility, but they had not tracked specific antibiotic use. *They had no documentation of audits that had been completed related to infection control. -They would have done random observations of staff for infection control and educated at that time if needed. That would not have been specifically documented. *Mandatory infection control training for the employees would have been completed online. *When asked about any additional hands-on training or if any areas of concerns had been identified: -They stated they would have done random observations and provided one-on-one education. -There was no documentation to support that had been completed. -They stated additional training would have been included in all staff inservices. *They were unsure when the bath aides had been trained or who had trained the bath aides on cleaning and disinfecting the whirlpool tubs. -Both bath aides had been working there "for years." *In general, in regard to a resident who would</p>	F 441	<p>3e. Administrator or designee will perform audits of hydrocollator. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation.</p> <p>3f. Administrator or designee will perform audits of wheelchair cushions so they are cleaned and stored. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation.</p> <p>4a. Substantial compliance achieved</p> <p>4b. Substantial compliance achieved</p> <p>4c. Substantial compliance achieved</p> <p>4d. Substantial compliance achieved</p> <p>4e. Substantial compliance achieved</p> <p>4f. Substantial compliance achieved</p>	<p>7/17/15</p>  <p>DJ/Sarah JJ</p>
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F 441	<p>Continued From page 60</p> <p>have been on isolation precautions for a contagious multidrug-resistant organism (MDRO) (infections that was hard to treat because it did not respond to most antibiotics) they stated:</p> <ul style="list-style-type: none"> -For an active infection staff would have been aware, because the isolation cart would have been outside that resident's door. -The department heads had a morning stand-up meeting every day and would have discussed any new concerns. -The charge nurse would have reported any concerns to the staff. <p>*For a resident who no longer was in isolation precautions and was considered colonized (had a history of being infected) with a MDRO:</p> <ul style="list-style-type: none"> -There was no specific tracking documentation for resident's who had a history of MDRO. -The DON stated "Nurse's should know, because they've been here a long time." -The diagnosis of the infection should have been in the resident's diagnosis list and on the care plan. -In order for a resident to be taken off isolation precaution, the resident would have had a repeat culture to indicate they were no longer actively infected. <p>*There was no separate infection control committee or meeting.</p> <ul style="list-style-type: none"> -They would have discussed it at the monthly quality assurance (QA) meeting. -They did not mention what they would talk about for infection control other than the quality measures such as urinary tract infections. <p>Interview on 6/24/15 at 8:25 a.m. with licensed practical nurse (LPN) A regarding infection control policies and isolation precautions for a resident identified with a MDRO revealed:</p> <p>*Nursing would only know if someone had a</p>	F 441			

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F 441	<p>Continued From page 61</p> <p>history of an infection by referring to the resident's chart.</p> <p>*If a culture showed a MDRO the infection control person from the hospital or laboratory should have called the facility and explained what to do.</p> <p>*The physician would have ordered specific instructions.</p> <p>*A resident would have needed a culture and physician's order to come out of isolation.</p> <p>Review of the provider's monthly inservices for the staff from January 2015 through the date of the survey revealed:</p> <p>*A 1/14/15 hand washing training that included the Centers for Disease Control (CDC) recommendations and a post-test.</p> <p>*A 3/11/15 safe food handling and hydration training that included an article on Disposable Glove Overuse in the Food Industry from 2012 and a post-test.</p> <p>*No other inservices addressed infection control specifically.</p> <p>Review of the provider's 12/18/14 Multidrug-Resistant Organisms policy revealed:</p> <p>***Appropriate precautions will be taken when caring for individuals known or suspected to have infection with a multidrug-resitant organism. (Note: Infection means that the organism is present and is causing illness. Colonization means that the organism is present in or on the body but is not causing illness.)"</p> <p>***Complete surveillance documentation (e.g.[for example], line history, reports) for residents who have a multidrug resistant organism infection/colonization."</p> <p>Further interview on 6/25/15 at 9:35 a.m. with the interim DON and the DON from another facility</p>	F 441		
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F 441	<p>Continued From page 62 revealed:</p> <p>*They agreed there had been no evidence of tracking or trending of infections per the previous DON's interview on 6/23/15 at 5:15 p.m.</p> <p>*They agreed infection control would have been discussed at QAPI, but it would be difficult to analyze and determine trends without tracking being completed.</p> <p>Review of the provider's 12/18/14 Infection Control Committee policy revealed: *"Our facility will have an infection control oversight function. The objectives may be attained as a component of the Quality Assurance and Performance Improvement (QAPI) Committee or by having a separate Infection Control Committee (ICC)." *Objectives included: -a. Assist in development and implementation of written policies and procedures for the prevention and control of infections among resident and personnel; -b. Provide the facility with a safe and sanitary environment. -g. Develop infection control orientation and in-service training programs for all levels of facility personnel; -h. Develop policies and procedure for the surveillance and monitoring of infection control practices;" *Duties included to "7. Assist in monitoring and assessing facility-wide environmental infection control/prevention practices." *Composition of the committee included "3. The administration shall provide all necessary logistical support for the committee or the committee's functions if assumed by the QAPI committee." *Delegation of Authority included:</p>	F 441		
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F 441	<p>Continued From page 63</p> <p>"1...The Administrator, will be responsible for oversight of the Infection Control Program.</p> <p>-2. The Infection Control Committee will oversee the use of proper prevention and control measures, and will help identify, investigate, and control outbreaks of infectious diseases within the facility."</p> <p>*Meetings included:</p> <p>"1. The Infection Control Committee shall meet whenever necessary, or it's functions will be covered by the QAPI Committee, at least monthly."</p> <p>"3. Over time, committee meetings will cover at least [the following but not all]:</p> <p>-b. Surveillance reports of infections or infectious diseases;</p> <p>-d. Current infection control/prevention concerns;</p> <p>-i. Antibiotic utilization patterns and emergence of antibiotic-resistant organisms;</p> <p>-j. Measures to prevent infections or exposures in the future; and</p> <p>-k. In-service training programs."</p> <p>2. Observation and interview on 6/23/15 at 11:25 a.m. with certified nursing assistant (CNA) D in the North tub room revealed:</p> <p>*It was a Superior Penner tub and was the newer tub in the facility.</p> <p>*She performed as a bath aide on occasion.</p> <p>*She had been trained on giving baths and cleaning the whirlpool tub years ago.</p> <p>*After giving a resident a bath in the whirlpool tub she would have:</p> <p>-Drained the water from the tub.</p> <p>-Rinsed the tub with water using the hand sprayer.</p> <p>-Sprayed everything down with the disinfectant from a spray bottle.</p> <p>-Waited ten minutes.</p>	F 441			

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F 441	<p>Continued From page 64</p> <p>-Then rinsed off the tub with water again with the hand sprayer. -It would then be ready for the next bath. *She only scrubbed the tub if there was an obvious dirty area. *She performed that procedure in-between all baths during the day. *Only at the end of the day would she have: -Filled the tub higher than the jets with water and disinfectant. -Ran the jets for five minutes, maybe longer. *She showed a spray bottle with the label worn off that contained a yellow liquid that she would have used to disinfect the tub. -She stated that bottle was filled from a bigger bottle of whirlpool disinfectant. -She agreed it should have had a readable label. *The larger bottle of disinfectant was labeled Classic Whirlpool Disinfectant Cleaner. *There were instructions in the tub room for how to clean the whirlpool tub, but she stated those were not current. *There had been no measurement of the amount of disinfectant used.</p> <p>Observation and interview on 6/25/15 at 9:05 a.m. with bath aide E in the West tub room revealed: *It was a Century whirlpool tub and was the older tub. *She had worked in the facility thirty-four years. *She only did residents' baths. *She had been trained on giving baths and cleaning the whirlpool tub years ago. *Most residents in the facility used the whirlpool tub instead of a shower. -She ran the jets for everyone every time they used the whirlpool tub. *After giving a resident a bath in the whirlpool tub</p>	F 441			

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F 441	<p>Continued From page 65</p> <p>she would have:</p> <ul style="list-style-type: none"> -Drained the water from the tub. -Rinsed out the tub with water using the hand sprayer. -Sprayed the seat and sides of the tub with a spray bottle that was labeled Whirlpool disinfectant. -Left the disinfectant on for ten minutes. -Used a washcloth to wipe it off. -She performed that procedure between all baths during the day. *At the end of the day she would have: -Put the drain stopper in. -Poured disinfectant into the bottom of the tub. She did not state a specific amount of disinfectant to be used. -Filled up the tub with water. -Ran the jets for fifteen to twenty minutes. *She only used a brush to scrub the tub at the end of the day. *There had been instructions of how to clean the tub posted on the wall in the room. *She did not recall anyone doing audits or competencies of the tub cleaning process. *She agreed if the tub had not been cleaned correctly that would have been a risk to other residents. <p>Review of the provider's undated tub cleaning instructions revealed:</p> <ul style="list-style-type: none"> **1. After draining water from tub, use stopper to plug drain and fill with water to just under the intake valve. *2. Add 2 ounces Whirlpool Disinfectant Cleaner and turn whirlpool on. *3. Run whirlpool for at least 10 minutes, drain tub and let air dry. *This is to be done after every use." 	F 441		
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F 441	<p>Continued From page 66</p> <p>Review of the Superior Sit-Bath System 6300 whirlpool tub manufacturer's instructions revealed:</p> <p>*To "clean and disinfect the tub after every bath with Penner Cleaner/Disinfectant..."</p> <p>*It indicated:</p> <ul style="list-style-type: none"> -To use disinfectant in the jets. -To use a long-handled brush to thoroughly scrub all interior surfaces of the tub. -Allow proper disinfectant contact time (usually 10 minutes or as recommended by the disinfectant's manufacturer). -Then rinse the tub's interior surfaces thoroughly with the hand sprayer. <p>Review of the Century Whirlpool Bathing Systems manufacturer's instructions for system cleaning after a bath revealed:</p> <p>*"Cen-Kleen is the only cleaning solution designed and recommended for use with the Century tub.</p> <p>-"You may use other brand cleaner/disinfectants, at your own risk. Other brand cleaner/disinfectants may have different formulations and/or chemical compositions.</p> <p>*For system cleaning with and without the cleaner disinfectant system included:</p> <ul style="list-style-type: none"> -To spray or run disinfectant into or through the whirlpool outlets. -To use a long handled brush and thoroughly scrub all interior surfaces of the tub. -After disinfecting, rinse the tub surfaces with water. <p>Review of the Classic Whirlpool Disinfectant Cleaner label revealed:</p> <p>*For disinfection:</p> <p>-"Apply properly diluted Classic Whirlpool Disinfectant Cleaner detergent/disinfectant so as</p>	F 441		
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F 441	<p>Continued From page 67</p> <p>to wet all surfaces thoroughly. -For routine disinfection, proper dilution is 1:64 (2 ounces of product per gallon of water). -Allow to remain wet for 10 minutes, then let air dry."</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and the DON from another facility revealed: *They agreed there was a risk to other residents if the whirlpool had not been cleaned and disinfected properly. *They agreed there had been no recent training documented for the bath aides. *They agreed the tub cleaning instructions had not been followed.</p> <p>3. Observation on 6/23/15 at 7:50 a.m. of the North wing tub room revealed: *A plastic container with the lid off sat on the back of the toilet with items that included: -Several combs. -Hair pick. -Cotton-tipped wooden applicators in a paper bag. -A yellow highlighting marker. -Rolls of plastic tape. -A fingernail clipper. -A tube of Calazime (skin protectant) cream. -A tube of antifungal cream. *There were white/gray hairs noted on the combs and debris in the bottom of the container. *There were no barriers separating the items from one another.</p> <p>Further observation on 6/24/15 at 10:20 a.m. revealed the above plastic container had the same items in it and was now in a cabinet.</p>	F 441			

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F 441	<p>Continued From page 68</p> <p>Observation on 6/24/15 at 10:55 a.m. of the West wing tub room revealed:</p> <ul style="list-style-type: none"> *A plastic container in the cabinet with items that included: <ul style="list-style-type: none"> -Several combs. -Hair picks. -Three bottles of perfume/body spray with no covers. -A roll of plastic tape. -A tube of Calazime cream. -Pens. -Wooden sticks in a cardboard box. -Cotton-tipped wooden applicators in a paper bag. -Toenail clippers. *Another plastic container in the cabinet with items that included: <ul style="list-style-type: none"> -Three solid deodorants. -A jar of body lotion. -A tube of skin protectant. -Nail clippers. -Scissors. *Both containers had white/gray hairs and pieces of debris in the bottom of the container. *There were no barriers separating the items from one another. *The tube of Calazime cream had a warning for external use only. *Some of the personal use items had residents' names on them and some did not. <p>Interview on 6/25/15 at 9:05 a.m. with bath aide E revealed:</p> <ul style="list-style-type: none"> *The items in the tub rooms in the above plastic containers were always stored that way. *Those items would have been used for many residents. <p>Review of the provider's 12/1/14 Cleaning and</p>	F 441			

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F 441	<p>Continued From page 69</p> <p>Disinfection of Non-Critical Resident-Care Items revealed: **"Reusable items are cleaned and disinfected or sterilized between residents." *5. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products [for the following] including: -c. Storage; -e. Safe use and disposal."</p> <p>4. Observation on 6/23/15 at 7:50 a.m. revealed resident 5 had a pedestal type fan in his room that was on and towards his bed. That fan was dirty with dust on the outer surface and the blades.</p> <p>Observation on 6/23/15 at 7:55 a.m. revealed resident 13 had a pedestal type fan in her room that was on and toward the wall. That fan was dirty with dust on the outer surface and the blades.</p> <p>Observation on 6/23/15 at 11:15 a.m. revealed two of three fans in the North hallway and one of three fans in the West hallway were on and blowing into the hallways. Those fans were covered with dust on the outer surfaces and on the blades.</p> <p>Review of the account manager duties list for the housekeeping laundry supervisor stated bi-weekly the fans and vents in the hallways should have been surface cleaned.</p> <p>Interview on 6/24/15 at 10:20 a.m. with housekeeper B revealed: *Housekeeping should have cleaned the fans in the hallways and the resident rooms when they were dirty.</p>	F 441		
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F 441	<p>Continued From page 70</p> <p>*They had not been on a cleaning schedule.</p> <p>Interview on 6/24/15 at 2:15 p.m. with the maintenance supervisor revealed: *Housekeeping was responsible for the cleaning of the fans. *They should have been cleaned monthly.</p> <p>Interview on 6/24/15 at 2:45 p.m. with the housekeeping/laundry supervisor revealed: *Both housekeeping and maintenance would have been in charge of the cleaning of the fans. *Maintenance would have been responsible for the inside of the fans, including the blades, because they would have to be taken apart.</p> <p>Further interview on 6/25/15 at 9:16 a.m. with the maintenance supervisor revealed: *He had not been aware housekeeping did not clean the inside of the fans. *He would now be doing them monthly.</p> <p>Review of the 10/1/14 services agreement with the housekeeping/laundry contract employees revealed: *The description of services for cleaning included: -"2.2.12 Spot Clean and wash exterior of ventilators, light covers, air diffusers." *The scheduling of services for cleaning included: -Daily spot cleaning for resident rooms and corridors.</p> <p>5. Observation and interview on 6/24/15 at 10:35 a.m. with physical therapy (PT) assistant G of the hydrocollator machine in the PT room revealed: *When the machine was opened there was a musty odor. *There had been a few hot packs in the water. *The machine should have been cleaned</p>	F 441		
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F 441	<p>Continued From page 71</p> <p>monthly.</p> <p>-That would have included draining, cleaning, and refilling with water.</p> <p>*She stated she had cleaned it within the last few weeks.</p> <p>*She agreed the Hydrocollator Equipment Cleaning and Temperature Tracking Form sheet did not reflect cleaning had been done at all since November 2014.</p> <p>*No residents were currently using the hydrocollator pads.</p> <p>Review of the November 2014 Hydrocollator Equipment Cleaning and Temperature Tracking Form on the clipboard in the PT room revealed:</p> <p>*No initials had been documented in the section for cleaning the machine.</p> <p>*The form indicated the unit was to have been cleaned at least monthly.</p> <p>Review of the provider's 8/17/14 Hot Packs policy revealed the equipment [hydrocollator] would be cleaned every two weeks and a cleaning log maintained.</p> <p>Review of the provider's 12/1/14 Prevention of Infection Level 1 for Physical Therapy policy revealed for the hydrocollator it should have been cleaned every six months and disinfected with an approved disinfectant.</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim DON and the DON from another facility revealed PT would have been responsible for the cleaning and maintenance of the hydrocollator machine.</p> <p>6. Observation on 6/24/15 at 10:35 a.m. of the soiled utility room revealed:</p> <p>*Two wheelchair cushions had been sitting in the</p>	F 441			

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F 441	<p>Continued From page 72</p> <p>two compartment sink. -Those cushions had covers on them with white and brown flecks all over the surfaces. *The faucet had been dripping water into the sink where the cushions had been sitting.</p> <p>Interview on 6/24/15 at 11:15 a.m. with licensed practical nurse A revealed the cushions should have been cleaned by housekeeping or laundry staff.</p> <p>Interview on 6/24/15 at 11:50 a.m. with housekeeper B revealed: *He had never been in the soiled utility room. *Housekeeping did not go in there to clean.</p> <p>Observation and interview on 6/24/15 at 2:45 p.m. with the housekeeping/laundry supervisor in the soiled utility room revealed: *He agreed the cushions were dirty. *Housekeeping would have cleaned the surfaces in the soiled utility room. *Nursing or the CNAs would have been responsible for cleaning the wheelchair cushions.</p> <p>Interview on 6/25/15 at 9:25 a.m. with the interim DON and the DON from another facility revealed the certified nursing assistants would have been responsible for cleaning the wheelchair cushions.</p> <p>Review of the 12/1/14 Cleaning and Disinfecting Non-Critical Resident-Care Items policy included the following: **3d. Reusable items are cleaned and disinfected or sterilized between residents. *Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including: -c. Storage.</p>	F 441		

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F 441 F 490 SS=H	Continued From page 73 -e. Safe use and disposal." 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, observation, interview, and job description review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being for all thirty-five residents residing in the facility. Findings include: 1. Review of the employee roster revealed: *Effective 2/10/14 a new executive director ([ED] administrator) had been hired. *Effective 6/23/15 the director of nursing (DON) had resigned. *Effective 6/23/15 an interim DON had been hired. *On 6/23/15 the Minimum Data Set (MDS) assessment nurse had been out on family medical leave. *Effective 6/30/15 the current medical director had resigned. *Effective 7/1/15 the new medical director would be hired. *Effective 1/26/15 the activity specialist had been hired.	F 441 F 490	F490 – EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 1. The facility is unable to correct past administrative concerns. All residents have potential to be effected by this process. 2. The facility is administered in a manner that enables it to use its resources effective and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 3. The Area Vice President (AVP) or designee will audit facility monthly for 6 months for progress on plan of correction and that residents are achieving and maintaining their highest practicable well being. Results will be reviewed at QAPI meetings for further recommendations. <i>Administrator will take audit results to QA monthly.</i> 4. Substantial compliance achieved <i>DW/SAP/H/JJ</i>	7/17/15

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F 490	<p>Continued From page 74</p> <ul style="list-style-type: none"> *Effective 1/20/15 the maintenance supervisor had been hired. *Effective 5/26/15 the consulting pharmacist had made the initial visit to the provider. *The provider had been utilizing the social worker from another facility for approximately two months since the social worker had resigned. *The dietary manager had been on family medical leave for approximately one month. <p>Review of the provider's 8/30/11 job description for Executive Director revealed:</p> <ul style="list-style-type: none"> *The general purpose was "To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents/patients while achieving the facility's business objectives." **"Oversees regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility; moral of the staff; and ensures resident needs are being addressed." **"Ensures the building and grounds are appropriately maintained and that equipment and work areas are clean, safe, and orderly, and any hazardous condition are addressed; ensure that Universal Precaution and Infection Control, Isolation, Fire Safety, and Sanitation practices and procedures are followed." **"Monitor Human Resources practices to ensure compliance with employment laws and company policies, and to ensure practice that maintain high morale and staff retention to include effective communication, prompt problem resolution, proactive supervisory practices, and maintaining a proactive work environment." **Utilize the quality improvement process in all 	F 490		
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F 490	<p>Continued From page 75 areas of facility operation."</p> <p>Review of the provider's 4/5/12 job description for the Director of Nursing revealed: *The general purpose was to "Plan, coordinate and manage the nursing department. Responsible for the overall direction, coordination and evaluation of nursing care and services provided to residents. Maintains quality care that is consistent with company and regulatory standards. Assumes responsibilities of daily operations in the absence of the Executive Director." **"Oversees the nursing staff for the provision of quality and appropriate resident/patient care that meets or exceeds company and regulatory standards." ***Schedules and performs rounds to monitor and evaluate the quality and appropriateness of nursing care." **"Conducts daily Clinical Start-up meeting with the interdisciplinary team to review resident and patient status." *Oversees and monitors the Resident Assessment process for accuracy, attends care planning conferences periodically to determine compliance with care planning guidelines." **"Collects, reviews and analyzes clinical outcome data and determines trends. Brings identified concerns to the QA&A [quality assessment and assurance] committee for development of appropriate plans of action."</p> <p>Phone interview on 6/25/15 at 11:50 a.m. with the medical director confirmed he had been aware of the staff turnover issues at the facility. He was also aware of the resident elopement and was aware the resident refused to wear the Wanderguard bracelet. He was not aware other</p>	F 490		
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F 490	Continued From page 76 alternatives had not been tried. The following deficiencies had been cited for the current licensure survey: F176, F280, F281, F309, F323, F371, F425, F441, F490, F514, and F520. Review of the last licensure survey completed on 4/24/14 revealed the following deficiencies had been cited and were being recited: F280, F281, F309, and F441. Review of a previous licensure survey completed on 1/30/13 revealed the following deficiencies were being recited: F280, F281, and F441.	F 490		
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. 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: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure accuracy of	F 514	F 514 RECORDS ACCURATE/COMPLETE 1. Facility unable to correct past assessments and signatures. All residents have the potential to be affected. * Facility unable to correct past assessments and signatures for residents 2, 3, 5, 6, 7 and 9. 2. All assessments going forward will be completed in full and signed by the nurse completing the assessment. Nurses inserviced on completing and signing all resident assessments. * 3. DNS/designee will audit assessments for completion/signature weekly x 4, x2 per month x 2 months. QA committee to determine continued action and monitor compliance. * Don will report to QA monthly. DW/5000H/JJ 4. Substantial compliance achieved Previously identified residents will be included in monitoring when their assessment is due. DW/5000H/JJ	7/17/15

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F 514	<p>Continued From page 77</p> <p>the medical record for the following:</p> <ul style="list-style-type: none"> *Three of nine residents' (2, 3, and 7) medical records reviewed had been signed by the licensed nurse when completed. *Two of nine residents' (6 and 7) medical records and observations revealed conflicting documented information. *Three of nine resident's (2, 5, and 9) medical records revealed assessments were thoroughly completed. <p>Findings include:</p> <p>1. Review of resident 2, 3, and 7's medical record revealed:</p> <ul style="list-style-type: none"> *Resident 2 had a 5/28/15 Quarterly Interdisciplinary Resident Review assessment that had not been signed by the licensed nurse who had completed it. *Resident 3 had a 3/12/15 through 3/13/15 Quarterly Interdisciplinary Resident Review assessment that had not been signed by the licensed nurse who had completed it. *Resident 7 had a 3/20/15 through 3/21/15 Quarterly Interdisciplinary Resident Review assessment that had not been signed by the licensed nurse who had completed it. <p>Surveyor: 35237</p> <p>2a. Review of resident 6's medical record revealed conflicting documentation from observations related to transfers, toileting, and bed mobility. Refer to F280, finding 5.</p> <p>Surveyor: 32572</p> <p>b. Review of resident 7's medical record revealed inconsistent documentation regarding cognitive (thought) processes. Refer to F323, finding 1.</p> <p>3a. Review of resident 2's medical record</p>	F 514		
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F 514	<p>Continued From page 78 revealed: *The 5/28/15 Quarterly Interdisciplinary Resident Review assessment had not been completed in the following areas: -Activities of daily living. -Bladder evaluation. -Balance during transitions (transferring from one place to another) and walking. -Functional limitation in range of motion (movement of joints). -Mobility devices. -Medications. -Risk for elopement (unauthorized leaving the facility). -Devices, restraints, and falls. -Safe smoking evaluation. -Pain.</p> <p>Surveyor: 35237 b. Review of resident 5's medical record revealed: *The 5/11/15 clinical health status assessment had not been completed in the following areas: -Diabetes foot screen. -Cardiovascular/circulatory (heart/blood). -Gastrointestinal (stomach). -Weakness. -Gait (walking). -Range of motion. -Sleep patterns. -Safe smoking evaluation.</p> <p>c. Review of resident 9's medical record revealed: *The 5/18/15 quarterly Interdisciplinary Resident Review assessment had not been completed in the following areas: -Activities of daily living. -Sleep patterns. -Risk for falls.</p>	F 514			

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F 514	Continued From page 79 d. Interview on 6/25/15 at 9:25 a.m. with the interim director of nursing (DON) and DON from another facility confirmed they would have expected the assessments to be complete. Surveyor: 32572 d. Interview on 6/25/15 at 11:07 a.m. with the interim director of nursing confirmed she would have expected resident medical records to be complete. And the licensed staff members to have signed the assessments when completed. Review of the provider's 1/29/14 The Medical Record policy revealed: **A Medical Record, Health Record, Clinical Record or Chart is a systematic documentation of the Resident's medical history and care." **"The Medical Record is the healthcare team's primary reference and communication tool." **"The Medical Record is a collection of recorded facts concerning the individual Resident. The Medical Record contains sufficient information to identify the Resident and his or her diagnosis, justify treatment, demonstrate the Resident's current condition, and to provide evidence that care is provided per the Care Plan and Long Term Care Standards." **"The guidelines for Documenting and Maintaining the Medical Record are: -Hand-written entries in the Medical Record must be signed (name and title) and dated. -Complete all forms leaving no blanks; consent forms should be double-checked."	F 514		
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	

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F 520	Continued From page 80 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns and to develop and implement corrective action. Findings include: 1. Interview on 6/24/15 at 2:15 p.m. with the maintenance supervisor revealed he was not sure what QA was and had not really heard anything about it.	F 520	1. The facility is unable to correct past administrative concerns. All residents have potential to be effected by this process. 2. Executive Director, Director of Nursing, Medical Director and Interdisciplinary team have reviewed the Quality Assurance and performance improvement policy 3. The Quality Assurance Performance Improvement (QAPI) program will include review of resident care concerns and plans, identify trends in the quality indicator measures, identify trends and tracking of infection controls, identify needs and issues with electronic medical records, review admissions and discharges, discuss new and old policies and procedures, discuss monthly pharmacist reports, discuss incident and safety reports, discuss staff concerns and needs. Staff members have been reeducated on the QAPI process. QAPI Committee meetings will be held at a minimum of quarterly consisting of the Executive Director, Director of Nursing, Medical Director and at least 3 other members of the facility staff. * Administrator will report monthly to the Board. PW/SDD/H/JJ 4. Substantial compliance achieved	7/17/15

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F 520	<p>Continued From page 81</p> <p>Further interview on 6/24/15 at 4:50 p.m. with the maintenance supervisor revealed he did attend the monthly QA meetings. He stated he would have given his "two cents."</p> <p>Interview on 6/24/15 at 2:36 p.m. with licensed practical nurse A revealed she was aware of a QA committee. She was not aware of what they had been working on.</p> <p>Interview on 6/24/15 at 3:20 p.m. with the activity coordinator revealed: *She had been employed since January 2015. *She was the only activity employee in the facility. -Therefore she would have been a department head. *She stated she did not normally attend the QA meetings that were held monthly. *She had not been aware of what was discussed at the meetings.</p> <p>Interview on 6/24/15 at 3:45 p.m. with the medical records coordinator revealed: *She had been employed for fourteen years. *She attended the monthly QA meetings. *She would have brought up issues specific to medical records. *She expected the DON and administrator to address the problems identified at QA.</p> <p>Interview on 6/24/15 at 3:30 p.m. with certified nursing assistant (CNA) N revealed she: *Had been employed for one week. *Had not heard anything about QA or QAPI (quality assurance performance improvement) before.</p> <p>Interview on 6/24/15 at 4:00 p.m. with CNA H</p>	F 520		
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F 520	<p>Continued From page 82 revealed she: *Had had been employed for three months. *Had not heard of QA or QAPI before.</p> <p>Review of the provider's QAPI attendance sheets for 2/25/15 revealed the administrator, director of nursing (DON), Medical Director, business office manager (BOM), Minimm Data Set (MDS) assessment nurse, social services coordinator, and the maintenance supervisor attended.</p> <p>Review of the provider's QAPI attendance sheet for 4/28/15 revealed the administrator, DON, Medical director, BOM, Activities Coordinator, and the maintenance supervisor attended.</p> <p>Review of the provdier's QAPI attendance sheet for 5/26/15 revealed the administrator, DON, Medical Director, BOM, medical records coordinators, and the maintenance supervisor attended.</p> <p>Refer to F490, finding 1.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*) from the previous survey on 4/24/14: F176, F280*, F281*, F309*, F323, F371, F425, F441*, F490, F514, and F520.</p> <p>Interview on 6/25/15 at 1:25 p.m. with the administrator, the interim director of nursing (DON), and the DON from another facility regarding the QA program revealed: *All department heads, the medical director, and the consultant pharmacist had been a part of the QA committee. *The committee met monthly. *The medical director usually attended monthly.</p>	F 520		
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F 520	<p>Continued From page 83</p> <ul style="list-style-type: none"> *Everyone brought information for the meeting. *The DON or administrator identified and decided if the information would be put on the agenda. *They had performance improvement project (PIP) committees that worked on something that needed improvement. -The PIP committee members would have been QA members. -If it was a nursing issue the DON would have been included. -Other issues, such as building issues, the administrator would have been included. *All staff would have been welcome to attend the monthly meetings and should have known what they were currently working on. *Staff should have been aware of QA/QAPI from the all staff meetings. <p>Review of the provider's August 2014 QAPI Committee Guideline revealed:</p> <ul style="list-style-type: none"> *"The QAPI Committee monitors and sustains Living Center operational performance in clinical and nonclinical systems through self identification and improvement in areas where opportunities for improvement (OFIs) have been identified. *The Executive Director [administrator]: -Was the process owner of the committee. -"Provides or coordinates training, facilitation and resources for process improvement initiatives." *There was a chart with five areas that included: -Review of Operations: clinical and non-clinical systems. -Identify OFIs: data review, trends, and observation. -Prioritize OFIs: high risk, high volume, problem prone areas. -Determine Root Cause: fishbone, 5 whys, process steps. -Implement PIP: SMART goal, ADLI, sustained 	F 520		
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 520	Continued From page 84 outcome. *Performance Improvement projects were to examine and improve care or services in the areas identified as OFIs. *PIP were concentrated efforts on a particular OFI."	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 07/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451	
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/23/15. Golden LivingCenter-Ipswich was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas in one randomly observed location (dry food storage room). Findings include:	K 029	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. K029 – NFPA 101 LIFE SAFETY CODE STANDARD 1. Self-closing device installed on 7/10/15. All residents have potential to be effected by this process. 2. Audit all storage rooms greater than 50 square feet housing a substantial amount of combustible goods and materials for self-closing device. 3. Maintenance Supervisor will conduct a one-time audit of the function of all self-closing devices to ensure smoke tight closure. Results of audit will be presented to QAPI committee for review and recommendation. 4. Substantial compliance achieved	7/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Handwritten Signature]

[Handwritten Title: ED]

[Handwritten Date: 7-17-15]

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

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If continuation sheet Page 1 of 2
SD DOH L&C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451		
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K 029	Continued From page 1 1. Observation at 11:35 a.m. on 6/23/15 revealed a storage room off the service wing corridor. The storage room was over fifty square feet and housed a substantial amount of combustible goods and materials. This deemed it as having a level of hazard greater than that normal to the general occupancy of the building and would therefore be classified as a hazardous room. That hazardous room shall be provided with a smoke tight, self-closing door. That room was provided with a smoke tight door but did not have a self-closing device installed. Interview with the maintenance supervisor at the time of the observation confirmed that finding.	K 029			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DR IPSWICH, SD 57451
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S 000	Initial Comments Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/23/15 through 6/25/15. Golden Living Center-Ipswich was found not in compliance with the following requirements: S210, S236, and S322.	S 000		
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure one of seven sampled employees (A) had documentation of a health evaluation completed within fourteen days of being hired. Findings include:	S 210	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. S210 - EMPLOYEE HEALTH PROGRAM 1. Employee H (employee A is listed in 2567 by accident) health evaluation was completed 7/14/15. All residents have potential to be effected by this process. 2. Business Office Manager educated on the need for a health evaluation to be completed for all employees hired. Audit all personnel records for health evaluations by 7/15/15. 3. Business Office Manager will perform audits of employee records to ensure that a health assessment is completed. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the BOM to monthly QAPI committee for review and recommendation. 4. Substantial compliance achieved	7/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

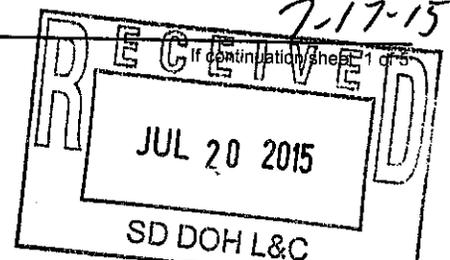
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
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S 210	<p>Continued From page 1</p> <p>1. Review of employee A's personnel record revealed: *A 3/23/15 hired date. *There was no documentation a health evaluation had been completed.</p> <p>Interview on 6/25/15 at 9:30 a.m. with the business manager regarding employee A revealed she: *Was unable to locate documentation of a health evaluation. *Thought they had completed one on her. *Did not have a policy regarding health evaluations.</p>	S 210		
S 236	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p>	S 236	<p>S236 – TUBERCULIN SCREENING REQUIREMENTS</p> <ol style="list-style-type: none"> Employee N and employee M (corrected from employee F and G on 2567) completed the two-step TB skin screen 6/25/15 and 7/9/15 respectively. Employee I (corrected from employee B on 2567) will complete the two-step TB skin screen on 7/27/15. All residents have potential to be effected by this process. Business Office Manager educated on the need for two-step TB screening to be completed for all employees hired. Audit all personnel records for two-step TB screening by 7/15/15. 	

South Dakota Department of Health

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S 236	<p>Continued From page 2</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure three of seven sampled employees (B, F, and G) had documentation the two-step Tuberculin (TB) skin screening had been completed within fourteen days of being hired. Findings include:</p> <p>1. Review of employee B's personnel file revealed: *A 6/4/15 hired date. *There was documentation one TB skin screening had been completed on 6/8/15. There was no documentation of the results of that TB screening. *There was no documentation the two-step TB skin screening had been completed.</p> <p>2. Review of employee F's personnel file revealed: *A 6/4/15 hired date. *There was documentation one TB skin screening had been completed on 6/8/15, and the results had been read on 6/11/15. *There was no documentation the two-step TB skin screening had been completed.</p> <p>3. Review of employee G's personnel file revealed: *A 5/30/15 hired date. *There was documentation one TB skin screening had been completed on 6/15/15, and the results had been read on 6/17/15. *There was no documentation the two-step TB skin screening had been completed.</p> <p>4. Interview on 6/25/15 at 10:00 a.m. with the</p>	S 236	<p>3. Business Office Manager will perform audits of employee records to ensure that a two-step TB screening is completed. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the BOM to monthly QAPI committee for review and recommendation.</p> <p>4. Substantial compliance achieved</p>	7/17/15

South Dakota Department of Health

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S 236	Continued From page 3 business manager regarding the above employees TB tests revealed she: *Would let the director of nursing (DON) know when a new employee needed TB screenings. *Was unable to locate further documentation regarding the above employees TB screenings. *The previous DON was no longer employed at the facility. Review of the provider's 11/18/14 TB Screening policy revealed "All new employees will receive a two-step TB skin screening with 14 days of being hired unless documentation within the previous 12 months."	S 236		
S 322	44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure physician's orders had been obtained for the release of medications upon discharge for one of one sampled resident (10). Findings include:	S 322	S322 – CONTROL AND ACCOUNTABILITY OF MEDICATIONS 1. There is no corrective action to be taken for resident 10 as this resident discharged 6/19/15. All residents have potential to be effected by this process. 2. Nursing staff was educated on the requirement of a physician order to discharge with medications. 3. Director of Nursing or designee will perform audits of residents prior to discharge to ensure that a physician order is obtained prior to discharging with medication. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the BOM to monthly QAPI committee for review and recommendation. 4. Substantial compliance achieved	7/17/15

South Dakota Department of Health

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S 322	<p>Continued From page 4</p> <p>1. Review of resident 10's medical record revealed: *A 5/29/15 admission date. *He was discharged to home on 6/19/15.</p> <p>Review of resident 10's 6/18/15 physician's order revealed: *An order to discharge him home when social services had home health services in place. *There was not an order to discharge medications home with him.</p> <p>Review of resident 10's 6/19/15 Medications Released on Leave of Absence revealed the following medications were sent with him: *Timolol eye drops (glaucoma). *Travoprost eye drops (glaucoma). *Clonazepam (sedative/hypnotic). *Bupropion (anti-anxiety). *Clobetasol cream (topical steroid). *Silver sulfa ointment (prevention and treatment of infections in burns). *Tramadol (narcotic-like pain reliever).</p> <p>Interview on 6/25/15 at 10:30 a.m. with the interim director of nursing regarding resident 10 revealed: *She was unable to locate a physician's order to discharge him with any medications. *There should have been a physician's order to send the above medications with him.</p> <p>Review of the provider's May 2012 Discharge With Medications policy revealed: *"Medications may be sent with the resident on discharge if ordered by the prescriber [physician]." *"The prescriber should list the medications to be released upon discharge."</p>	S 322		