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F 309	Continued From page 89 changes." On 12/12/13 at 9:44 a.m., LPN #2 was asked who was responsible for resident #3's pain management. She stated, "Dr. [name withheld] and each nurse." She was asked what was done with the information obtained during pain assessments. She stated, "Chart it and medicate according to the assessment." She was asked what caused resident #3 to have pain. She stated, "She has MS and is super contracted." She was asked what she did to minimize the resident's pain during activities known to cause pain. She stated she tried to make sure the resident had her pain medication, and she assessed to see if it worked. She stated the resident requested pain medication be given before each tube feeding. She was asked what the resident's pain medications were. She stated, "Norco and Aleve, Baclofen, Neurontin." She was asked when the last time the resident's pain medication had been adjusted. She stated, "I don't know. As long as I been taking care of her they've been the same." She stated she had been at the facility less than six months. She was asked why those specific medications were chosen. She stated, "I don't know." She was asked why the resident had been told that she was on the strongest pain medication	F 309		

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F 309	Continued From page 90 she could be on. She stated, "I don't know who told her that." On 12/12/13 at 11:00 a.m., the medication administration record was reviewed. It was documented the resident had received Baclofen 20 mg, Aleve 220 mg, and one tablet of Norco 7.5/325 mg at 9:00 a.m. On 12/13/13 at approximately 9:50 a.m., Dr. [name withheld] was asked if staff had informed him that the resident had increased pain with pressure ulcer dressing treatment. He stated, "I'm not too sure about that." The physician stated the resident's pain would never be completely relieved due to her diagnoses. He stated that sometimes, just breathing on the resident could cause her excruciating pain. He stated because of the resident's diagnoses, her pain was extremely difficult to manage. He was informed that the resident's routine pain medication was Aleve. He stated, "That's nothing." He was asked what he would have done if he had known the resident was having increased pain with her pressure ulcer treatments. He stated, " I would have increased her pain medication." He was asked if he depended on staff to inform him of resident's pain levels and issues with pain. He stated, "Yes I do, they are my eyes and my ears. I depend on them." The physician was asked if he knew why someone had decreased the resident's as needed Norco 7.5/325 mg from two tablets every four hours to one tablet, when it was known that	F 309		

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one tablet did not control her pain. He stated, "No, I don't."

On 12/17/13 at 9:00 a.m., the DON was asked who was responsible for the pain management program. She stated, "I am." She was asked how she monitored the program. She stated the quality assurance team audited and looked at the CMA and nurse pain assessments.

The DON was asked how she ensured residents' pain was controlled effectively and to the best level possible. She stated she expected staff to ask the resident about their pain after taking pain medication and if it was not controlled, she expected the nurses to follow up. She stated morning rounds were made with the nurses and she reviewed the twenty-four hour reports.

The DON was asked what she did if she identified the pain program was not being effective either as a system or for a specific resident. She stated all aspects of care would be reviewed and a solution would be found. She stated she would continue to monitor.

2. Resident #16 was admitted to the facility on 10/02/13 with diagnoses that included a lower limb ulcer, depression, bipolar disease, and chronic pain.

The resident's admission assessment, dated 10/11/13, documented the resident was cognitively intact, had frequent pain, and the pain made it hard to sleep. It was documented the resident rated her worst pain at a six on a zero to ten scale. It was also documented the resident had no skin conditions.

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The resident's care plan for pain, last updated 10/26/13, documented a problem, "...has dx of chronic pain, myositis [and] myalgia, wounds BLE...She is receiving routine Lyrica, Ultram, Percocet, and Voltaren gel to knees BID. With medication her stated pain level is 2...Without pain medication her stated pain level is 6 - 7..." The goal was, "...will receive medications as ordered and achieve her stated pain level goal of 2 - 3 thru next review..." Approaches included, "...Medication for pain is not to be held or altered without physician order to do so ..Administer pain medication, PRN and routine, as ordered...Pain is what [resident #16] says it is, if relief not obtained, consult physician to change or add to medication ordered..."

Monthly physician orders, dated 12/2013, documented the resident was to receive Lyrica 50 mg twice daily for chronic pain, Percocet (a narcotic pain medication) 10/325 mg every six hours for chronic pain, and Ultram (a narcotic pain medication) 50 mg every 6 hours for chronic pain. It was also documented the resident could receive one Percocet 10/325 mg every 24 hours as needed for pain and acetaminophen 650 mg every four hours as needed for pain.

Review of medication administration records, dated 12/09/13 at midnight through 12:00 p.m., documented the resident had received her routine pain medications as ordered but no as needed medications had been administered.

On 12/09/13 at 12:20 p.m., the resident was observed sitting in her wheelchair in her room. Her lunch tray was on her overbed table, and she was rocking back and forth, moaning, and was short of breath. The resident was asked what

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was wrong. She stated her right lower leg was hurting. The resident showed the surveyor three wounds she had near her right ankle. She was asked if the wounds were hurting. She stated, "Yes." The resident was asked what she would rate her pain level at. She stated, "About a 9." She was asked what a tolerable level was for her. The resident stated, "A 3, 4, or 5. It never goes away, but today is extremely worse." The resident was asked when she had pain medications last. She stated, "About 8:30 a.m. They won't give me any closer than four hours. It's about time."

The resident was asked if she told anyone she was in pain. She stated, "Just the aide." The resident stated, "When [CMA #1] brought my meds this morning, I was ok. Then it got excruciating." The resident stated she had finished her shower around 10:00 a.m. She stated the pain had become worse then, and she had told the aide. The resident was asked which aide she told. She stated, "[CNA #3]." The resident was asked when she informed the aide she was in pain. She stated it was right after her shower, at approximately 10:00 a.m. She stated she had also told the aide who had brought her lunch tray, but she could not remember her name.

At 12:27 p.m., CMA #1 entered the resident's room. The resident asked her, "Brought my pain med?" CMA #1 nodded her head yes. She asked the resident if she needed her "itch" medicine. The resident stated yes and asked, "Can you slip in a another pain med?" The resident stated she was hurting "really bad." CMA #1 stated, "Can't do that."

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F 309	Continued From page 94 CMA #1 left the room to obtain the resident's anti-itch medication. The resident was asked if there had been any other time when her pain had been greater than her tolerable level. She stated, "Yes, quite often. I can't have any thing but every four hours." At 12:31 p.m., CMA #1 re-entered the room. She asked the resident, "On a scale of one to ten, where is your itching?" The resident asked, "My pain?" The CMA stated, "No, your itching." CMA #1 did not ask the resident about her pain. At 12:49 p.m., CMA #1 was asked if the resident took as needed pain medications. She stated, "It's very seldom she asks me for one." On 12/09/13 at 12:55 p.m., CNA #3 was asked if the resident told her she was in pain. CNA #3 stated, "She told me she wasn't feeling good." CNA #3 stated, "She said her foot was bothering her." She was asked who she told the resident was in pain. She stated, "Let me see, I told somebody but I can't remember who I told." CNA #3 was asked what she looked for to see if a resident was in pain. She stated, "Expressions on the face, verbally if they say something." She was asked if she remembered who she told the resident was in pain. CNA #3 stated, "To be truthfully honest, I can't remember and I'm thinking I didn't." At 1:12 p.m., LPN #3 prepared to do wound care on the resident's right lateral ankle wounds. She entered the room and began the wound care. LPN #3 applied a lidocaine cream to the areas surrounding the wounds. The resident stated, "It's really hurting today." LPN #3 asked when it started hurting so bad. The resident stated it had	F 309		

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began hurting throughout the night. She stated the pain was "really bad" and she could not go to the bathroom because of the pain. LPN #3 did not ask the resident to describe or rate her pain.

LPN #3 was asked if the wound care caused the resident pain. She stated, "Just the cleaning gives her discomfort." She stated that was why the lidocaine cream was placed on the peri-wound prior to beginning the wound care. LPN #3 was asked if she asked the resident about her pain prior to beginning. She stated, "No."

LPN #3 progressed with the wound care after allowing the lidocaine cream time to work. As she cleaned the first wound, the resident cried, 'Oh, oh, oh." The resident stated, "I try not to scream and holler, but it hurts."

LPN #3 was asked when the resident was medicated for pain. She stated, "She usually gets it at eight and noon. It's every four hours." She was asked if she asked the resident to rate her pain before beginning the wound care. She stated, "No."

LPN #3 was asked what the facility's policy and procedure was for medicating before wound care or dressing changes. She stated, "Make sure they are medicated before. If it doesn't work, use something like lidocaine." LPN #3 was asked how she knew what the resident's pain was before beginning the wound care. She stated, "I didn't. I just knew she would have pain."

On 12/17/13 at 9:00 a.m., the DON was asked who was responsible for the pain management program. I stated, "I am." She was asked how

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F 309	Continued From page 96 she monitored the program. She stated the quality assurance team audited and looked at the CMA and nurse pain assessments. The DON was asked how she ensured residents' pain was controlled effectively and to the best level possible. She stated she expected staff to ask the resident about their pain after taking pain medication and if it was not controlled, she expected the nurses to follow up. She stated morning rounds were made with the nurses and she reviewed the twenty-four hour reports. The DON was asked what she did if she identified the pain program was not being effective either as a system or for a specific resident. She stated all aspects of care would be reviewed and a solution would be found., She stated she would continue to monitor. 3. Resident #12 was admitted to the facility on 11/15/15 with diagnoses that included diabetes mellitus type II, osteomyelitis, chronic pain, cervical spinal stenosis and benign prostatic hypertrophy with urinary obstruction. The resident had an indwelling urinary catheter. Admission physician's orders, dated 11/15/13, documented, "...Begin bladder training...Will start bladder training..." The care plan did not address bladder training. Treatment sheets, dated 11/2013, documented, "...bladder training..." It was initialed as completed two to three times a day from 11/16/13 through 11/19/13. Treatment sheets, dated 12/2013, documented,	F 309		

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"...bladder training..." All dates were blank.

A form titled "Potential bowel and bladder retraining" was in the resident's clinical record. The form was blank.

A form titled "Three day bladder tracking wheel" was blank except for the resident's name and room number.

On 12/11/13 at 11:10 a.m., LPN #9 was asked what kind of bladder training was done for resident #12. She stated, "I haven't done any on him."

At 11:16 a.m., the DON was asked what kind of bladder training was done for resident #12. She stated, "I am not familiar with the bladder training program."

On 12/13/13 at 3:00 p.m., the DON stated she had reviewed the bladder training program. She stated if a resident had an indwelling catheter, the staff was to clip the tubing off several times a day and increase the time it was clipped over time.

She was asked where is it documented the resident received bladder retraining. She stated the documentation should have been in the nurses' notes.

4. Resident #5 was admitted to the facility on 05/03/13 with diagnoses that included CVA, diabetes mellitus, and neuropathy.

A quarterly assessment, dated 09/23/13, documented the resident was cognitively intact, required extensive assistance of one person with dressing and had impairment in range of motion

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of one upper extremity.

needed with locomotion, and had a stage II pressure ulcer.

A physician's order, dated 10/12/13, documented, "...to wear edema glove L U/E glove to be pulled up to shoulder with no wrinkles to be worn 22 - 23 hrs a day..."

A care plan, dated 10/13/13, documented, "Problem:.ADLS...LUE ...edema glove to pull up to shoulder with no wrinkles to be worn 22 - 23 hours a day..."

On 12/10/13 at 8:24 a.m., a wound dressing was observed on the resident. She did not have a glove on her left arm.

At 3:35 p.m., the resident was observed on center hall as she propelled herself in her wheelchair. She did not have a glove on her left arm.

On 12/12/13 at 9:20 a.m., the resident was observed leaving the smoking room. She was not wearing a glove on her left arm.

At 11:28 a.m., the resident was observed in the center hallway without an edema glove. She was asked if she had an edema glove for her left arm. She stated, "Yes, they put in on for an hour every day."

She was asked if she had swelling in her left hand and fingers. She stated, "Yes, I do."

On 12/12/13 at 1:52 p.m., LPN #2 was asked if the resident was to wear an edema glove on her left hand and arm. She stated, "I've seen her with

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it on but there is not a treatment sheet for it."

She was asked who was responsible for ensuring the edema glove was worn if there was a physician's order for one. She stated, "Me but it's not on the treatment sheet."

On 12/12/13 at 3:00 p.m., the DON and LPN #8, the restorative nurse, were asked if the resident had a physician's order for an edema glove for her left hand and arm. LPN #8 stated, "Therapy gave me the order, and I spoke with the doctor, and he was ok with it."

They were asked how the restorative aide knew when to put on the glove and when she should remove it. The LPN stated the order documented when the glove should be put on and taken off.

They were asked if the resident had the edema glove on. The LPN stated, "I guess she doesn't. I told the restorative aide to place it on the resident on the 7-3 shift when she arrived at the facility and it is to be removed at the end of the 3-11 shift."

They were asked what the physician's order stated. LPN #8 stated, "Wear 22-23 hours a day."

The LPN was asked if the resident had worn the glove as ordered. She stated, "No."

The LPN was asked who was responsible to ensure the glove was worn as ordered. She stated, "Me."

The DON was shown the physician's order for the edema glove. She was asked if the resident had

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F 309	Continued From page 100 worn the glove as ordered by the physician. She stated, "No." The DON was asked if the care plan was followed regarding the edema glove. She stated, "No."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide feeding assistance to one (#17) of four sampled residents who required feeding assistance. The facility identified 17 residents as being dependent on staff for eating. Findings: Resident #17 was admitted to the facility with diagnoses that included congestive heart failure, psychosis, and dementia. Dietary progress notes, dated 04/15/13, documented, "eating 80 to 100% of her meals without significate [sic]weight loss..." A document, titled Dietary MDS questions, dated 06/05/13, documented, "Food consumed: eats 76 - 100%...meal assistance needed: none..." A care plan, dated 09/05/13, documented, "...Problem:..resident was severely impaired [in]	F 312	F312 1. Resident #17 was placed at an assisted table for encouragement, supervision, and cueing on 12/10/13. 2. All residents who require assistance or encouragement with meals have the potential to be affected. Dining room observation was conducted to identify any other residents needing assistance. 3. Nursing staff was inserviced by the DON on 1/3/14 to provide assistance, cueing and encouragement to any resident who is not eating their meal. 4. Audits will be completed of dining room meal time to ensure residents are provided assistance, cueing and supervision as necessary weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/31/14

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F 312	Continued From page 101 cognition for activities of daily living and needed supervision, oversight, encouragement or cueing with eating..." Physician orders, dated 12/2013, documented no dietary supplement was ordered for the resident. An annual assessment, dated 12/03/13, documented the resident needed supervision while eating, including oversight, encouragement, and cueing. It was documented the resident had a weight loss. Review of facility weight records revealed the resident had not had a weight loss. On 12/09/13 at 12:15 p.m., resident #17 was observed at lunch. She was sitting in a wheelchair at the dining room table. Her head was bent down, and she was holding her silverware, wrapped in a napkin, in her lap. At 12:17 p.m., the resident's spoon and fork slid from the napkin, onto the floor. Resident #17 put the knife on the table. At 12:19 p.m., the resident attempted to take a bite of food with her fingers. No staff approached her for assistance, cueing, or encouragement. At 12:26 p.m., the resident had not attempted to eat. No staff approached her for assistance, cueing, or encouragement. At 12:29 p.m., CNA #6 told resident #17, "Eat or its going to get cold." The resident said said something that was unintelligible. The CNA stated, "Eat a bite and then you can lay down." The resident was looking down at her lap.	F 312		

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The CNA did not pick up the resident's silverware up off the floor or provide the resident clean silverware.

At 12:31 p.m., the resident took two sips of juice, took her knife out of the napkin, and placed it on the table.

At 12:40 p.m., the resident moved her bowl of fruit cocktail closer to her on the table. She did not attempt to eat. No staff approached the resident for assistance, cueing, or encouragement. She was not provided clean silverware.

At 12:50 p.m., CNA #6 asked the resident, "Are you not hungry?" The resident stated, "Yes" and looked down at the silverware on the floor. The CNA asked the resident if she wanted a hamburger. The resident stated, "Yes."

At 12:54 p.m., CNA #6 gave the resident a hamburger and french fries.

At 12:57 p.m., the resident was not attempting to eat. CNA #6 was writing down meal percentages and did not speak, cue, or assist the resident to eat.

At 12:58 p.m., the resident slid the hamburger off her plate onto the table and looked at it.

At 1:04 p.m., CMA #3, CNA #6, and LPN #8 were observed cleaning plates of food from the tables in the dining room. They did not speak to the resident.

At 1:05 p.m., the resident took two sips of juice

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and then took a bite of onion. LPN #8 watched the resident and did not cue, assist, or encourage the resident to eat.

At 1:10 p.m., LPN #8 asked, "Did you throw the fork on the floor? Why are you so tired? Did you not sleep well last night? Eat one of your fries, they are right there."

At 1:14 p.m., LPN #8 asked the resident if she was done eating. The resident took a sip of juice, touched the hamburger but did not pick it up, then took a sip of juice. She ate a french fry.

At 1:19 p.m., LPN #8 asked the resident if she was done eating as she stood against the wall behind the resident.

At 1:21 p.m., LPN #8 left the dining room. The resident sat in the dining room and did not eat.

An ADL record for meal percentages, dated 12/09/13, documented the resident at 25% of the noon meal.

On 12/17/13 at 10:02 a.m., the DON was asked how staff knew if a resident required assistance with eating. She stated, "From the initial assessment."

She was asked if there was anyone observing the dining rooms during meals. She stated a nurse was assigned to each dining room and should see if a resident required assistance.

She was asked why resident #17 did not receive assistance with eating. She stated she would have to look into the situation.

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F 314 SS=D
483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to identify and implement interventions to aid in the healing and/or prevention of pressure ulcers for one (#12) of eight sampled residents who were reviewed for pressure ulcers The facility identified 34 residents as having pressure ulcers.
Findings:

The facility's policy on pressure ulcers and skin breakdown, dated April 2013, documented, "...The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressures; for example, immobility...In addition, the nurse shall assess and document/report the following:..full assessment of pressure sore including location, stage, length, width and depth...resident's mobility status...The physician will authorize pertinent orders related to wound treatments, including...application of topical agents..."

Resident #12 was admitted to the facility on

F 314
F 314

F314
1. Resident #12 no longer resides in this facility.
2. All residents who have pressure ulcers or are at risk have the potential to be affected. A skin audit is performed on all residents within the facility weekly.
3. Nursing staff was in-serviced on procedure for notification upon identification of new pressure ulcers and providing treatment per physician orders on 1/12/14 by Risk Manager.
4. Audits to ensure wound care is completed per physician order and identification of new wounds is communicated will be conducted weekly x 4, monthly x 3 and as needed. Results will be reviewed in Quality Assurance.

Completion date: 1/31/14

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F 314	Continued From page 105 11/15/13 with diagnoses that included diabetes mellitus type II, osteomyelitis, chronic pain, and cervical spinal stenosis. A resident data collection form, dated 11/15/13, documented, "...skin intact no skin breakdown noted neck surgical incisions intact..." A body audit form, dated 11/17/13, documented no skin problems. The resident's care plan, dated 11/19/13, documented, "...Problem: Potential for skin breakdown...decrease in mobility secondary to generalize[d] muscle weakness, he requires assistance with toileting and incontinent care...He noted [sic] fragile skin...has Dx of Diabetes...Approaches: Weekly skin audit. Document all new skin condition and report to PCP...Reposition [resident] every 2 hours as needed..." An initial assessment, dated 11/22/13, documented the resident was cognitively intact, needed extensive assistance with ADLs, had an indwelling urinary catheter, was incontinent of bowel, and had no pressure ulcers. A Braden scale for predicting pressure sore risk, dated 11/22/13, documented the resident scored a 15. This indicated the resident was at risk to developing pressure ulcers. A body audit, dated 11/24/13, documented the resident did not have a skin problem. A daily skilled nurses' note, dated 11/24/13 at 7:00 p.m., documented, "Resident noted to have redness to buttocks. N/O to apply calmoseptine	F 314		

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to buttocks q shift until resolved..."

A body audit form, dated 12/05/13, documented, "...sacrum red, excoriated..."

A body audit form, dated 12/08/13, documented, "...2 small open superficial areas to sacrum..."

A physician's order, dated 12/08/13, documented, "...calmoseptine to buttocks q shift & prn. Dx: open areas..."

An update to the care plan, dated 12/08/13, documented, "...Calmoseptine to buttocks Q shift & prn. Dx open area..."

A daily skilled nurses notes, dated 12/08/13 at 9:30 p.m., documented, "...Wound nurse noted superficial open areas to buttocks. N/O calmoseptine Q shift prn. Bedpan provided as order..."

Medication administration records, dated 12/08/13 and 12/09/13, documented the calmoseptine was applied three times each day.

On 12/10/13 at 2:16 p.m., a resident interview was conducted. The resident stated the staff did not answer his call light. He also stated staff would put him on the bed pan and not come back.

He was asked how long staff left him on the bed pan. He stated, "One time it was two hours. I timed it once, and it was one hour and fifty minutes." He was asked if he had turned his call light on. He stated, "Yes, it was on the whole time."

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On 12/11/13 at 8:03 a.m., the resident was asked if he had any problems with his skin. He stated, "Yes."

He rolled over onto his right side and three stage II pressure ulcers, approximately 1cm x 0.5cm each, were observed on his upper buttocks and left buttock. The ulcers were in an arched pattern, similar to the outline of a bed pan. He stated, "They are starting to itch."

At 8:55 a.m., the resident was asked when he had been left on the bed pan. He stated, "An hour this week." He stated it was either Monday, Tuesday, or Sunday. He stated he had been left on the bed pan for "a couple of times" for two hours or more.

He was asked when he had been left of the bed pan for two hours or more. He stated, "It was in this room, two weeks ago in the afternoon. It was [CNA #16]. She told me they were busy. I knew she wasn't because I heard her talking to people in the hall."

On 12/11/13 at 9:02 a.m., LPN #9 was asked if the resident had a treatment for his stage II pressure ulcers. She stated, "They have a facility cream that they put on when a bottom is red."

LPN #9 pulled a tube of cream out of the treatment cart. It was labeled "skin repair cream."

She was asked who used this cream. She stated the nurses had to put it on. She stated it was supposed to be documented on the resident's chart.

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On 12/11/13 at 9:17 a.m., the resident was asked if staff had applied a cream to his bottom. He stated, "They use some kind of salve."

He was asked who applied the salve, CNAs or LPNs. He stated, "Both."

He was asked when they had applied the cream. He stated when he had a bowel movement. He was asked how many times a day the cream had been applied. He stated, "I only have a bowel movement one time a day."

On 12/11/13 at 10:45 a.m., CNA #6 was asked what she did to help prevent pressure ulcers. She stated, "I turn them and keep them dry."

She was asked when she placed someone on a bed pan, what she did to make sure she did not forget them. She stated, "I just know."

She was asked if resident #12 had any skin breakdown. She stated, "Yes." She was asked how long he had breakdown. She stated about two weeks.

On 12/11/13 at 11:05 a.m., CNA #10 was asked what he did to help prevent pressure ulcers. He stated, "I turn residents at least every two hours and I assist them out of bed if the resident is able."

He was asked what he did when he placed someone on a bed pan to make sure he did not forget about them. He stated he usually just stepped out the door until they are finished.

He was asked if resident #12 had any skin breakdown. He stated he did not know because

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F 314	Continued From page 109 he had just started working the hall the resident was on two days previously. On 12/11/13 at 11:10 a.m., LPN #9 was asked if resident #12 had any skin breakdown. She stated he had "redness" to his bottom. She was asked if he had any open areas. She stated, "A couple of areas were open today." She was asked how she monitored the CNAs to ensure they were implementing interventions to aid in prevention of skin breakdown. She stated, "I usually have to do it myself or I ask the CNAs." She was asked how she ensured CNAs were providing quality care. She stated, "I make rounds and ask them if there are changes." On 12/17/13 at 9:00 a.m., the DON was asked who was responsible for identifying interventions to aid in the prevention and healing of pressure ulcers. She stated, "Everyone." She stated input was obtained from the charge nurses, physical therapy, and the weekly wound meetings. She was asked how she monitored to ensure interventions were identified and implemented. She stated through the quality assurance process. On 12/17/13 at 9:53 a.m., the DON was asked how she ensured residents were not left on bed pans for prolonged periods of time. She stated the aides were supposed to check frequently and that she was unaware of any problems with this. She stated she reviewed the call light response times on the computer. She was asked if she was aware the resident had	F 314		

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F 314	Continued From page 110 breakdown on his coccyx area. She stated she was aware of two red and opened areas. The DON was asked who applied the medication to the opened areas. She stated the nurses were to apply the medication on each shift. She was asked if she was aware it was documented the resident was receiving the cream on each shift but the resident stated it was only being applied once a day. She stated, "No." She stated the amount of medication left when the resident discharged from the facility showed it was being applied more than once per shift. The DON was asked how often skin checks were performed. She stated weekly by the wound team on the weekends. She stated the aides also documented any concerns on the bath sheets.	F 314		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 328	F328 1a. Resident #15 and #18 colostomy bags were replaced on 12/11/13. 1b. Resident #12 no longer resides in this facility. 2. All residents with a colostomy or PICC line have the potential to be affected. On 12/17/13, all residents with dressings were checked to ensure that the dressings had been changed as ordered. 3. All staff was in-serviced by the DON on 01/13/14 regarding dressing changes and colostomy bag changes.	1/21/14

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F 328	Continued From page 111 review, it was determined the facility failed to: A. Ensure necessary colostomy care was provided for two (#15 and #18) of four sampled residents with colostomies. The facility identified eight residents as having colostomies; and B. Ensure intravenous catheter dressing changes were provided for one (#12) of one sampled resident with an intravenous catheter. The facility identified one resident as having an intravenous catheter. Findings: A facility policy on peripheral IV dressing changes, dated 12/2011, documented, "...The purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings... Label dressing with date, time, and initials... The following should be documented in the resident's medical record:..Date, time, type of dressing, and reason for dressing change..." The facility's policy and procedure on colostomy/ileostomy care, dated 10/2010, documented, "...The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter...Wash and dry hands...Put on gown if soiling of clothing with feces is likely...Put on gloves...Remove drainage bag...Remove gloves, wash hands, put on clean gloves...Cleanse skin with appropriate skin cleansing	F 328	4. Audits to ensure dressing changes are completed as ordered and appropriately will be conducted weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	

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preparation...Evaluating the condition of the resident's skin...Replace with clean drainage bag... Documentation...Document the procedure in resident's documentation form...Reporting information in accordance with facility policy and professional standards of practice..."

1. Resident #18 was admitted to the facility on 11/18/13 with diagnoses that included a stage III pressure ulcer and colostomy.

The resident's care plan, dated 11/18/13, documented a problem, "...requires extensive to total assist with bathing, bed mobility, toileting, dressing..." The goal was, "...will have assistance with all her ADL functions to have her needs/wants met on a daily basis thru next review..." Approaches included, "...Empty foley catheter and colostomy pouch with each shift and as needed when noted that is is full...Place call light within easy reach when in room, answer promptly when activated..."

Another problem was, "...has diverting colostomy in place...is bedfast and nonambulatory..." One goal was, "...will not develop stoma complication/obstruction..." Approaches included, "...Empty colostomy pouch q shift and prn, do not let colostomy pouch become full...Change colostomy pouch as needed..."

Another problem was, "...has multiple medical condition[s]..." One goal was, "...s/sx of exacerbation of COPD, CHF, A-Fibb [sic] will be identify [sic] thru nursing assessment..." Approaches included, "...Encourage to avoid gas forming foods beans, cabbage, cauliflower, onions..."

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The resident's admission assessment, dated 11/25/13 documented the resident was cognitively intact, required extensive assistance with bed mobility and toilet use, and limited assistance with personal hygiene. It was documented the resident had a colostomy and urinary catheter.

On 12/11/13 at 5:03 a.m., a very strong smell of feces was noted from the hallway to be coming from the resident's room.

The resident's light was off and the surveyor entered the resident's room. The resident asked, "Ma'am, can you help me? My colostomy needs to be changed out, and I can't do it." The surveyor asked the resident if she had pushed her call button for assistance. The resident asked, "Where is it?" The call light was observed to be between the resident's mattress and the left upper side rail. It was out of the resident's reach. The call light was given to the resident, and she pushed the button. The resident was noted to have dried feces covering her left hand. The resident's gown and bed linens were covered with feces. The resident's abdomen was exposed and feces was noted to cover her abdomen.

At 5:08 a.m., CNA #1 entered the resident's room. The resident informed the CNA she required assistance with her colostomy. CNA #1 turned on the light. Liquid feces was puddled in the juncture of the resident's legs. The resident's urinary catheter tubing was in the feces. The colostomy bag was expanded with air and feces, and feces was noted to be draining between the skin and the seal of the colostomy bag.

CNA #1 removed the resident's soiled gown and the top sheet. She bundled them up, and without

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bagging the linens, left the room, went down the center hall, and placed them in the soiled linen hamper. She stopped at room #30 on the center hall and requested CMA #7's help.

CNA #1 told CMA #7 the resident's colostomy had burst. The surveyor asked CNA #1 if the bag burst or was it full. CNA #1 stated, "It's full. It's coming out." CNA #1 was asked how often she checked on the resident. She stated, "Every two hours." She was asked when the resident was checked last. She stated, "I don't know the exact time. Between 3:00 and 3:30 [a.m.]." CNA #1 was asked if she checked the resident's colostomy bag. She stated, "No, I didn't." She stated, "When I come in I check the bags and colostomy." CNA #1 was asked when she started her shift. She stated 11:00 p.m. She was asked when she emptied the colostomy. She stated at the beginning and end of her shift.

At 5:16 a.m., CMA #7 entered the room to assist the resident and CNA #1. They began to clean the resident.

At 5:18 a.m., CMA #7 ungloved and left the resident's room. She did not wash her hands before leaving the room.

At 5:19 a.m., CMA #7 returned to the room with a new colostomy bag. CNA #1 stated everywhere else she had worked, the nurses changed the colostomy bags. The colostomy bag was placed on the overbed table.

At 5:20 a.m., CNA #1 removed her gloves and left the room without washing her hands. She returned at 5:22 a.m. with clean linens, wipes, and trash can liners. CNA #1 and CMA #7

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F 328	Continued From page 115 continued to clean the resident. At 5:25 a.m., the resident was repositioned in bed. Dried rings of liquid feces were noted on the resident's incontinent pad. CMA #7 took the resident's call light, which was stained with dried feces, and placed it over the oxygen concentrator. CMA #7 took off her gloves and left the room without washing her hands. Her gloves were visibly soiled with feces. At 5:28 a.m., CMA #7 returned to the room with more wipes. CMA #7 told CNA #1 feces was still coming out of the resident's colostomy. CNA #1 drained the colostomy into a trash can liner. Feces continued to come from the stoma, leaking onto the resident and the mattress. CNA #1 placed the liner into the trash can and wiped the feces from the mattress using a disposable wipe. CMA #7 and CNA #1 continued to clean the resident. The resident was repositioned and stains were noted on the resident's mattress. A large white stain was noted near the resident's head, on the left side of the mattress. At 5:44 a.m., CMA #7 told CNA #1 that she had to leave so that she could do her job. CNA #1 asked for the nurse to be notified that she needed help. CMA #7 removed her gloves, and without washing her hands, left the room. CNA #1 began to give the resident a bed bath. The surveyor left the room. At 5:58 a.m., the surveyor returned to the room. CNA #1 was observed to be finishing placing the new colostomy bag on the resident. CNA #1 gathered the soiled linens from the bed bath,	F 328		

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placed them in a bag, and without washing her hands, left the room. She went down the center hall, placed the bag of soiled linens in the hamper, and went into room #52 and washed her hands.

CNA #1 was asked how long she had worked at the facility. She stated she had been there since August, 2013. She was asked if anyone had completed a skills competency check for her. She stated, "No." She stated she had worked on another hall with a person for one night and then came to the center hall and had worked independently.

CNA #1 was asked if she had put the new colostomy bag on the resident. She stated, "Yes." She was asked if she had been trained to replace colostomy bags. She stated, "No. That was my first one ever." CNA #1 was asked if there was enough staff on her shift to meet the residents' needs. She stated, "Usually. That's the worst thing that's happened. I was trying to get people up and that consumed all my time. The resident had to wait."

On 12/12/13 at approximately 8:30 a.m., the corporate nurse stated she had reviewed the cameras. She stated the aide had been in the resident's room seven times during her shift. The corporate nurse provided documentation of the times the CNA had entered the room. The time the CNA spent in the room on each visit ranged from two to six minutes. It was documented another staff member, either an RN or CMA, entered the room at 4:44 a.m. and spent 12 minutes in the room.

The surveyor explained the aide had stated she

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F 328	Continued From page 117 had not checked the resident's colostomy bag since the beginning of the shift. The corporate nurse stated the resident had ate beans and cabbage for the previous evening meal, causing increased gas. She stated some nursing homes did not check the colostomy bags but once per shift. On 12/17/13 at approximately 3:00 p.m., a copy of the competency checklist for CNA #1 was provided to the surveyor. The checklist did not include colostomy care or replacing colostomy bags. On 12/17/13 at 9:18 a.m., the DON was asked what training the aides received regarding colostomy bags. She stated, "I need to look into that. They are trained to empty every shift." She was asked how the staff would know if the resident had gas-causing foods. She stated the menu was documented on the board by the nurses' station. She was asked what staff was expected to do if they knew a resident had consumed gas producing food. She stated they should check the colostomy more often. The DON was asked who was responsible for changing the bag. She stated, "The nurse helps the CNA unless the nurse has instructed the CNA on how to do it." 2. Resident #12 was admitted to the facility on 11/15/15 with diagnoses that included diabetes mellitus type II, osteomyelitis, chronic pain, and cervical spinal stenosis. Admission physician's orders, dated 11/15/13, documented, "...PICC drsg [change] q week &	F 328		

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F 328	Continued From page 118 prn..." An initial assessment, dated 11/22/13, documented the resident was cognitively intact and was receiving intravenous medication therapy. A care plan, dated 11/15/13, documented, "...Problem:..is receiving IV medications for Dx of osteomelitis...PICC dressing changes Q week as ordered..." On 12/09/13 at 9:40 a.m., the resident's PICC line dressing was observed. The date on the dressing was 11/15/13, the day the resident was admitted to the facility. On 12/11/13 at 10:35 a.m., LPN #3 (the wound nurse) was asked how often PICC line dressing was to be changed. She stated, "One time a week." She was asked who was responsible for changing the PICC line dressing. She stated, "Nurses." She was asked, according to documentation, when was it changed. She stated, "Last night." She was asked why the dressing was dated 11/15/13 when it first observed on 12/09/13. She stated, "I thought it was an RN's duty." On 12/11/13 at 10:45 a.m., LPN #2 was asked how often PICC line dressings were supposed to be changed. She stated, "Every week." She was asked who was responsible for changing the PICC line dressing. She stated,	F 328		

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F 328	Continued From page 119 "Nurses." On 12/11/13 at 11:16 a.m., the DON was asked what the facility's policy was on PICC line dressing changes. She stated, "The wound nurse does it. I think every 72 hours." She was asked how she monitored to ensure dressing changes were completed as ordered. She stated, "QA monitors wounds and dressings." On 12/17/13 at 9:25 a.m., the DON was asked who was responsible for changing PICC line dressings. She stated the charge nurses. She was asked who monitored to ensure the nurses were completing the dressing changes. She stated the quality assurance team. She was asked how the monitoring took place. She stated through random audits. She was asked why the dressing change was not completed for resident #12. She stated, "I don't know." 3. Resident #15 was admitted to the facility on 08/09/13 with diagnoses that included multiple sclerosis, muscular disuse atrophy, paraplegia, and colostomy. A facility form, labeled skin and dated 10/10/13, documented, "...Colostomy care [every] shift per protocol...Frequency: 7-3; 3-11; 11-7..." A quarterly assessment, dated 11/06/13, documented the resident was cognitively intact and was totally dependent on staff for transfers, toilet use, and bathing. Bowel continence documented, "...Appliances: ostomy..." Review of facility records revealed no documentation regarding the procedure staff was	F 328		

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to use to empty the colostomy bag, nor did the facility's policy and procedure address the protocol for emptying or fitting the colostomy bag.

On 12/16/13 at 2:33 p.m., resident #15 was asked who was responsible for her colostomy care. She stated, "A lot of them try." She stated the colostomy bag was always too large for her stoma. She stated, "I try to tell them."

She was asked when the staff provided colostomy care. She stated, "When I start griping." She stated the staff did not rinse the colostomy bag after emptying it. She stated staff wiped the inside of the end of the bag with a "baby wipe."

At 2:45 p.m., resident #15's colostomy bag was observed to have a moderate amount of formed stool and air in the bag. The colostomy bag had a copious amount of feces lining the inside of the bag to the very end which was folded over once and clipped. Approximately one inch of the end of the bag was exposed past the clip.

The bag's end that had been left exposed had not been cleansed of feces and was positioned next to the resident's skin. The bag's end was observed stuck together with dried feces.

The resident was asked if the colostomy bag was usually folded once with the end exposed with feces and placed next to her skin after staff has emptied the bag. She stated, "Yes. I've had it drip down my side." She stated feces often got on her clothes.

On 12/17/13 at 9:18 a.m., the DON was asked what training the CNAs received on colostomy

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F 328	Continued From page 121 bags. She stated, "I need to look into that." She was asked how they were taught to clean the colostomy bag. She stated, "We just know to rinse with soap and water." She was asked how the CNAs were taught to fit the colostomy bag to the stoma. She stated, "That would be the nurses." She was asked who was responsible for changing the colostomy bag. She stated the nurses helped the CNAs, unless the nurse had instructed the CNA on the procedure.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 1a. Resident #14 blood pressure was taken on 12/13/13. 1b. Resident #22 restoril was decreased to PRN on the MAR on 12/16/13. 1c. Resident #28 had x 2 multivitamin tabs d/c'd on 12/27/13. 2. All residents who receive medication have the potential to be affected. A review of telephone orders and MARs was completed to ensure no unnecessary medication was being administered on 1/12/14. 3. Nursing staff was inserviced by DON and physician coordinator on 1/12/14 regarding unnecessary medication and order transcription.	1/21/14

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F 329	Continued From page 122 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure three (#14, #22, and #28) of 29 sampled residents who were reviewed for unnecessary medications did not receive medications without adequate monitoring, in excessive doses, or against physician orders. The facility identified 163 as taking medications. Findings: 1. Resident #14 was admitted to the facility on 08/20/13 with diagnoses that included hypertension, chronic kidney disease stage III, and diabetes. Physician monthly orders, dated 09/2013, documented the resident was to receive Lisinopril 40 mg and carvedilol 3.125 mg every day for hypertension. It was ordered for the resident's blood pressure to be monitored weekly due to hypertension. Review of medication administration records, dated 09/2013, revealed documentation the resident's blood pressure was taken on 09/03/13. There was no documentation to show the resident's blood pressure was monitored at any other time during the month. Review of medication administration records, dated 10/2013, revealed documentation the resident's blood pressure was taken on 10/14/13 and 10/29/13. There was no documentation to	F 329	4. Audits will be conducted to ensure telephone orders are transcribed weekly x 4, monthly x 3 and as needed. Audits will be done monthly by the Consulting Pharmacy to review for unnecessary medications. Results will be reported to the Quality Assurance meeting.	

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F 329	Continued From page 123 show the resident's blood pressure was monitored at any other time during the month. Review of medication administration records, dated 11/2013, revealed documentation the resident's blood pressure was taken on 11/13/13 and 11/19/13. There was no documentation to show the resident's blood pressure was monitored at any other time during the month. A quarterly assessment, dated 11/20/13, documented the resident had an active diagnosis of hypertension. On 12/16/13 at 8:28 a.m., CMA #3 was asked how often the resident's blood pressure was checked. He reviewed the medication administration records and stated it was to be checked weekly on Tuesdays and monthly on the 14th as part of vital sign checks. He was asked why the resident's blood pressure was monitored. He stated it was because everyone's blood pressure was checked either daily, weekly, or monthly,. He stated, "He's not on any medications for his blood pressure." On 12/16/13 at 8:52 a.m., the DON was asked what the facility's policy was for monitoring blood pressures. She stated skilled residents were checked every shift. She stated if a long term care resident was on blood pressure medications, their blood pressure should be checked prior to giving the medication. The DON was asked how she ensured the CMAs and nurses were monitoring blood pressures as ordered and per current standards of practice for a resident receiving anti-hypertensive medications. She stated through random audits	F 329		

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of the chart. She was asked why the resident's blood pressure was not being monitored as ordered by the physician. She stated, "I would have to ask the CMA why it isn't being done."

2. Resident #22 was admitted to the facility with diagnoses that included dementia and insomnia.

A quarterly assessment, dated 09/16/13, documented the resident was severely impaired in cognition for activities of daily living, had signs of inattention, and disorganized thinking.

The resident's care plan, dated 09/24/13, documented, "...Problem:..history of depression...Approaches: Administer trazodone as ordered...Observe for ...insomnia..."

A consultation report, dated 10/01/13 through 10/29/13, documented, "...Comment:..resident has an order for Temezepam [Restoril] 15 mg QHS for insomnia. Recommendation: Please consider changing to a PRN basis. Physician's response: I accept the recommendation above, please implement as written..."

The physician signed the recommendation on 10/31/13.

Monthly physicians' orders, dated November 2013, documented, "...Restoril 15 mg capsule 1 po at bedtime...dx: insomnia..."

A physician's order, dated 11/08/13, documented, "...N/O
Restoril 15mg cap 1 PO at HS..."

A nurse's note, dated 11/08/13, documented, "N/O Restoril 15 mg cap 1 PO @ hs dx insomina

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[sic] D/C Restoril 15mg cap 1 po @ hs as needed dx insominia [sic]"

A medication administration record, dated 11/2013, documented, "Restoril 15 mg cap 1 po @ hs..."
The record documented the resident received Restoril at 9:00 p.m. on 11/08/13 through 11/20/13.

Monthly physicians' orders, dated 12/2013, documented, "...Restoril 15 mg capsule 1 po at bedtime...dx: insomnia..."

A medication administration record, dated 12/2013, documented, "Restoril 15 mg cap 1 po @ hs..."
The record documented the resident received Restoril at 9:00 p.m. on 12/01/13 through 12/15/13.

On 12/16/13 at 4:20 p.m., the DON was asked who was responsible for ensuring the resident's medication orders were correct. She stated, "The charge nurses."

She was asked who ensured the charge nurse transcribed the medications correctly. She stated, "I do."

The DON was asked how she ensured the physicians' orders were transcribed correctly. She stated, "I get one of the three copies of the physician's order."

She was asked who received the pharmacist's recommendations. She stated, "I do. We QA'd it two months ago. The ADON and I have written the orders but I wrote this one because it was a

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psychotropic drug."

She was asked who monitored her. She stated, "The administrator and the pharmacist."

3. Resident #28 was admitted to the facility with diagnoses that included pressure ulcers, quadriplegia, muscle spasms, and neuropathy.

A physician's order, dated 10/31/13, documented, "Multiple vitamin w-minerals 1 PO every day. Dx: supplement."

A physician's order, dated 11/07/13, documented, "Decubi vite capsule 1 PO twice daily. Dx: wound healing supplement."

An admission assessment, dated 11/07/13, documented the resident had a BIMS score of 15. This score indicated the resident was independent with cognitive skills for daily decision making. The assessment also documented she required extensive assistance to total dependence in activities of daily living, had pain almost constantly, rated the pain intensity at an eight, and was admitted with one stage three pressure ulcer.

A physician's order, dated 11/09/13, documented, "Tab-a-Vite with iron tablet 1 PO every day. Dx: supplement."

Medication administration records, dated 11/2013, documented the resident received a multivitamin with minerals daily for that month. It also documented the resident received Decubi-Vite one by mouth twice daily starting the evening of 11/07/13 through 11/30/13.

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F 329	Continued From page 127 Medication administration records, dated 12/2013, documented the resident received a multiple vitamin with minerals daily from 12/01/13 through 12/16/13. It also documented the resident received Decubi-Vite capsule twice daily from 12/01/13 through 12/16/13. It documented the resident received Tab-a-Vite with iron daily from 12/01/13 through 12/16/13. On 12/16/13 at 11:47 a.m., CMA #8 was asked if she knew why the resident had orders for three different multiple vitamins. She stated, "No." At 11:49 a.m., LPN #9 was asked why the resident was on three different multiple vitamins. She stated, "Usually when they are on multivitamins it's for wound healing. I would ask [LPN #3, the wound nurse]." At 4:40 p.m., LPN #3 was asked why the resident was taking three different multiple vitamins. She stated, "I don't know why. I don't use vitamins for my wounds because they are water soluble. I prefer to use protein powder, and med pass. They typically come in on vitamins at admit or the dietician will order it."	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 332	F332 1. A medication error report was completed on resident #12, #44, and #45. 2. All resident who receive medications have the potential to be affected. The MAR was reviewed to ensure medications were given appropriately. 3. Nursing staff was inserviced by	1/21/14

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F 332	Continued From page 128 ensure a medication error rate of less than 5% for 3 (#12, #44, and #45) of 12 sampled residents who were observed during the medication passes. Three errors were observed during 25 opportunities of medication administration. This resulted in a medication error rate of 12%. The facility identified 163 residents as receiving medications. Findings: 1. The 12/2013 monthly physicians' orders for resident #44, documented, "...Novolog 100 unit/ml vial...6 units Sub -q three times daily before meals..." On 12/09/13 at 3:29 p.m., the resident was to receive 6u of Novolog before the evening meal. LPN #5 looked for the resident's insulin. She stated, "There isn't any insulin with his name on it." She went to the medication room and did not find the resident's insulin. She stated, "You can ding me because he is a brittle diabetic and I don't want him to bottom out. I will use another resident's insulin." The pharmacist stated, "No, I will get it [insulin] for you." At 4:25 p.m., the pharmacist brought a bottle of Novolog insulin for the resident. 2. The 12/2013 monthly physicians' orders for resident #12, documented "...Humalog 100...use per sliding scale directions... FSBS 150 - 200 = 2 units Humalog FSBS 201 - 250 = 4 units Humalog FSBS 251 - 300 = 6 units Humalog	F 332	the DON, pharmacy consultant, and physician coordinator regarding medication administration and reordering of medications on 1/12/14. 4. Audits will be conducted to ensure medications are administered appropriately and reordered appropriately weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	

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F 332	Continued From page 129 FSBS 301 - 350 = 8 units Humalog FSBS 351 - 400 = 10 units Humalog..." On 12/10/13 at 10:07 a.m., CMA #3 was observed as she performed FSBS on resident #12. The resident's FSBS was 165. This indicated the resident needed two units of Humalog per the sliding scale. LPN #5 stated, "I have to look for the rest of insulin in there [medication room]." She looked in the medication room and stated, "I don't have any for the resident in the medication room. Sorry, but I've been off for a week." She told the resident he would have to wait for insulin before she could give his shot. 3. The 12/2013 monthly physicians' orders for resident #45, documented, "ASA 81 mg qd c food." At 10:07 a.m., CMA #3 administered the aspirin to the resident. He did got give the resident a snack or offer food. On 12/11/13 at 11:47 p.m., CMA #3 was asked what the facility's policy was for administrating a medication that was ordered to be given with food. He stated, "I would give it after she ate." He was asked when resident #43 ate last. He stated, "She ate at breakfast." He was asked what time was breakfast served. He stated 7:30 to 8:00 a.m. He was informed he administered the resident at 10:07 a.m.	F 332		

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F 332	Continued From page 130 He was asked if the aspirin was given with food. He stated, "No." He was asked if he offered her any food. He stated, "She usually gets it after breakfast. I was late giving it." He was asked when he usually administered the aspirin. He stated, "8:30 to 9:00 a.m., when I see her leave the dining room." He was asked if he administered the medication with food. He stated, "No, I didn't. I was nervous."	F 332		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	F353 1. Care was provided to resident #15 and Resident #18. 2. All residents have the potential to be affected. Staffing patterns and needs were evaluated to ensure effectiveness and efficiency of staffing. 3. All nursing staff was educated regarding answering of call lights and colostomy care by the DON on 1/17/14. 4. Audits will be completed to ensure call lights are answered in a timely manner and colostomy care is provided per policy weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance meeting.	1/21/14

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure there were sufficient staff to meet the needs of the residents on two (north and center) of four halls. This had the potential to affect 100 residents who resided on the North and Center Halls. Findings:

The facility's policy and procedure, titled Answering the Call Light, dated October 2010, documented, "...General guidelines...Answer the resident's call as soon as possible..."

1. Resident #15 was admitted to the facility on 08/09/13 with diagnoses that included multiple sclerosis, chronic pain, muscular disuse atrophy, paraplegia, and colostomy.

The care plan, dated 08/09/13, documented, "...Problem/
Need...ADLs...Has dx of MS and is extensive or total assist with ADLs...Approaches...Call light within easy reach at all times...Answer promptly..."

A quarterly assessment, dated 11/06/13, documented the resident was cognitively intact and was totally dependent on staff for transfer, toilet use, and bathing.

On 12/16/13 at 2:33 p.m., when the surveyor knocked on resident #15's door her call light came on. When the surveyor entered the resident was sitting in her wheelchair next to her bed. She stated she had just turned

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her call light on to get juice.

The resident was asked how long it usually takes staff to respond to her call light. She stated, "20 to 30 minutes, sometimes over an hour."

She was asked if she felt there was enough staff to meet her needs. She stated, "No, this place is full to the max and there are only three people for the center hall and this hall." She stated, "It's shift change, evenings is always short staffed."

At 3:24 p.m. the DON entered resident #15's room and asked, "[Name withheld] you need something? The resident stated, "I just wanted some apple juice."

It was observed that it took 51 minutes for staff to respond to Resident #15's call light.

2. Resident #18 was admitted to the facility on 11/18/13 with diagnoses that included a stage III pressure ulcer and colostomy.

On 12/11/13 at 5:03 a.m., a very strong smell of feces was noted from the hallway to be coming from the resident's room.

The resident's light was off and the surveyor entered the resident's room. The resident asked, "Ma'am, can you help me? My colostomy needs to be changed out, and I can't do it." The surveyor asked the resident if she had pushed her call button for assistance. The resident asked, "Where is it?" The call light was observed to be between the resident's mattress and the left upper side rail. It was out of the resident's reach. The call light was given to the resident, and she pushed the button. The resident was noted to

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have dried feces covering her left hand. The resident's gown and bed linens were covered with feces. The resident's abdomen was exposed and feces was noted to cover her abdomen.

At 5:08 a.m., CNA #1 entered the resident's room. The resident informed the CNA she required assistance with her colostomy. CNA #1 turned on the light. Liquid feces was puddled in the juncture of the resident's legs. The resident's urinary catheter tubing was in the feces. The colostomy bag was expanded with air and feces, and feces was noted to be draining between the skin and the seal of the colostomy bag.

At approximately 5:10 a.m., CNA #1 was asked how often she checked on the resident. She stated, "Every two hours." She was asked when the resident was checked last. She stated, "I don't know the exact time. Between 3:00 and 3:30 [a.m.]." CNA #1 was asked if she checked the resident's colostomy bag. She stated, "No, I didn't." She stated, "When I come in I check the bags and colostomy." CNA #1 was asked when she started her shift. She stated 11:00 p.m. She was asked when she emptied the colostomy. She stated at the beginning and end of her shift.

On 12/17/13 at 2:39 p.m., the DON was asked what the average call light response time was. She stated, "Five to eight minutes." She was asked where call lights were supposed to be located. She stated, "Within residents' reach."

3. On 12/16/13 at 4:01 p.m., the ADON was noted to be sitting at the north nurses' station. She was looking at her cell phone. The call lights for residents #33, #42, and #43 were observed to be going off. A pager was noted on the desk at

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the nurses' station. It was noted to beep.

The ADON put her phone down and began looking through a chart on the desk. The call lights continued to go off.

At 4:05 p.m., MDS coordinator #1 was observed walking down the north hall. She stopped and assisted resident #43. LPN #4 exited the room for resident #33 and de-activated the call light. The ADON remained seated at the nurses' station.

At 4:06 p.m., an unidentified CNA was observed to walk down the hall, notice the call light for resident #42, and enter the room to assist the resident.

At 4:07 p.m., the ADON was asked what her title was. She stated she was the ADON. She was asked how staff would know if call lights were going off. She picked up a pager off the desk and stated there was a pager system for call lights. As she picked up the pager, it beeped. The ADON was asked if she was aware that while sitting at the nurses' station, three call lights had been going off. She stated, "No, I wasn't. I was looking at a chart."

On 12/17/13 at 2:39 p.m., the DON was asked what the average call light response time was. She stated, "Five to eight minutes." She was asked where call lights were supposed to be located. She stated, "Within residents' reach."

The DON was asked how staff knew if a call light had been activated. She stated the facility used a pager system and through observations. The DON was asked what her expectation was for all

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F 353	Continued From page 135 staff members if a call light was noted to be going off. She stated, "Any staff member is supposed to answer the lights."	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure dishes were washed with detergent and correct levels of chemical sanitation. This had the potential to affect 156 residents who ate food from the kitchen. Seven residents received nutrition and hydration solely from a feeding tube. Findings: The facility's policy on sanitation and infection control, revised 09/27/11, documented, "...Test the chlorine ppm on low-temperature machines daily to ensure proper sanitation of dishes..." Dish machine temperature records for 12/2013, documented from 12/01/13 through 12/06/13, the level of sanitizer in the dish machine was read at 100 ppm each day. There was no documentation the sanitizer level was checked on 12/07/13 and	F 371	F371 1. The sanitizer level was filled on 12/9/13. 2. All residents who receive nutrition and hydration through the kitchen have the potential to be affected. The chemical sanitation in the dish machine was corrected on 12/9/13. 3. Dietary staff was inserviced by the chemical vendor on 12/9/13 on chemical levels and monitoring. Chemical levels are reported daily. 4. Audits will be conducted on dish sanitation levels and monitoring weekly x 4, monthly x 3, and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/31/14

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F 371	Continued From page 136 12/08/13. On 12/09/13 at 10:00 a.m., DA #1 was observed running the dish machine. She was asked to check the chemical sanitation level. A test strip was placed on a dish in the machine during the sanitizing cycle. The strip did not register any chemical sanitation. DA #1 checked the sanitizing level again. The strip did not register any chemical sanitation. She stated, "Hadn't checked it yet this morning." The lines were checked and primed. There were no results for either detergent or sanitizer. The lines were primed again with no results. Cook #1 then primed the lines twice with no results. Cook #1 primed the line once more and detergent and sanitizer were both noted. The dietary manager stated all the dishes would be washed again and the company would be called to check the dish machine.	F 371		
F 425 SS=E	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	F 425	F425 1.Resident #16 completed her Clindamyacin. Resident #20 had a clarification order written to d/c coumdin and lovenox. Resident #12 no longer resides in the facility. Resident #44 receives his insulin per physician order. 2. All residents who receive medication have the potential to be affected. The MARs were reviewed	1/21/14

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F 425	Continued From page 137 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: Based on observation, interview, and record review, it was determined the facility failed to obtain medications and/or administer medications in a timely manner and/or transcribe physician medication orders correctly for six (#12, #16, #20, #25, #28, and #44) of 36 sampled residents whose medications were reviewed. The facility identified 163 residents as receiving medications. Findings: 1. Resident #16 was admitted to the facility on 10/02/13 with diagnoses that included a lower limb ulcer, depression, bipolar disease, and chronic pain. A physician's telephone order, dated 11/11/13 and timed 11:00 a.m., documented, "...Clindamycin [an antibiotic] 300 mg 4x's a day x 7 days...cellulitus to [right] ankle..." A nurse's note, dated 11/11/13 at 10:00 p.m., documented, "...Resident new order for Clindamycin antibiotic has not been delivered at this time..." Review of medication administration records,	F 425	to ensure that medication is being given appropriately 3. All CMAs and nurses were inserviced on 1/12/14 regarding medication administration and following the PIG method. 4. MARS will be monitored weekly x 4, monthly x 3 and as needed to ensure that medications are available and given as ordered. Results will be reviewed in the Quality Assurance meeting.	

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dated 11/11/13, revealed no documentation the Clindamycin was started.

A nurse's note, dated 11/12/13 at 6:00 p.m., documented, "...resident cont on Clindamycin antibiotic for infection..."

Review of medication administration records, dated 11/12/13, revealed documentation the resident received the first dose of Clindamycin at 9:00 p.m. on 11/12/13.

A physician's telephone order, dated 11/13/13 and timed 2:10 p.m., documented, "...T/O resume Clindamycin @ [6:00 p.m.]..." Review of the clinical record revealed no physician's order to hold the Clindamycin, and there was no documentation showing why it should have been held.

On 12/16/13 at 10:57 a.m., LPN #4 was asked when the medication was started. She stated, "Looks like it was started at 1300 [1:00 p.m.] on the 12th." She was asked how long it took to get medications from the pharmacy. She stated, "Usually the next day or the next run."

LPN #3 was asked why there was an order to resume the medication dated 11/13/13 and where the documentation was to support why it was held after giving the initial dose. She stated, "Maybe she told someone she was having a reaction." She was asked if that information should be in the clinical record. She stated, "I don't see anything specific."

LPN #3 was asked should there have been an order to hold the medication. She stated, "Sometimes they say we can use nursing

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judgement, but I didn't see any documentation in the nurses' notes."

On 12/17/13 at 9:37 a.m., the DON was asked who was responsible for ordering medications. She stated that new medications were ordered by the nurse who took the order and re-ordering was completed by the CMAs.

The DON was asked how she monitored to ensure medications were available. She stated the quality assurance team and CMA #9 monitored.

2. Resident #20 was admitted to the facility on 07/01/10 with diagnoses that included end-stage renal disease.

A physician's order, dated 09/17/13 at 1:30 p.m., documented the resident was to receive Lovenox, a blood thinner, 60 mg subcutaneously every twelve hours.

Another physician's order, dated 09/17/13 at 1:30 p.m., documented the resident was to receive Coumadin, a blood thinner, 5 mg every day, starting 24 hours after the Lovenox was started.

A pharmacy proof of delivery shipment detail, dated 09/17/13, documented the Lovenox and Coumadin were sent by the pharmacy. It was documented the medications were received at the facility on 09/18/13 at 12:35 a.m.

Review of medication administration records, dated 09/2013, documented the resident did not receive the first dose of Lovenox until 6:00 p m. on 09/18/13.

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F 425	Continued From page 140 A nurse's note, dated 09/19/13 a 6:00 p.m., documented, "...Lovenox 60 mg sq bid. To start Coumadin 5 mg po tonight..." Review of medication administration records, dated 09/19/13, revealed the resident received a dose of Coumadin at 6:00 p.m.. On 12/17/13 at 9:37 a.m., the DON was asked who was responsible for ordering medications. She stated that new medications were ordered by the nurse who took the order and re-ordering was completed by the CMAs. The DON was asked how she monitored to ensure medications were available. She stated the quality assurance team and CMA #9 monitored. 3. Resident #12 was admitted to the facility on 11/15/13 with diagnoses that included diabetes mellitus type II, osteomyelitis, chronic pain, and cervical spinal stenosis. The resident's pain care plan, dated 11/19/13, documented, "...Problem: Pain...c/o pain on his back, neck and that extended to his arms and finger and has leg pain. Relates pain is 10 in 0-10 scale. Relates medication helps... Approaches:..pain medication as requested every four hours...N/O D/C oxycodone HCL 30 mg 1 po q 4 hours prn changes to oxycodone HCL 30 mg 1 tab po q 4 hours routinely..." An initial assessment, dated 11/22/13, documented the resident was cognitively intact, needed extensive assistance with ADLs, had an indwelling urinary catheter, was always	F 425		

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incontinent of bowel, and received scheduled and as needed pain medications.

A physician's order, dated 11/25/13, documented, "...N/O D/C oxycodone HCL 30 mg [one] q 4 hours prn changed to oxycodone HCL 30mg [one] tab q 4 hours routinely..."

The narcotic record, dated 11/2013, documented the resident received oxycodone HCL as follows:

11/25/13 - five times;
11/26/13 - five times;
11/27/13 - five times;
11/28/13 - six times;
11/29/13 - six times; and
11/30/13 - six times.

The narcotic record, dated 12/2013, documented the resident received oxycodone HCL as following:

12/01/13 - six times;
12/02/02 - one time;
12/03/13 - four times;
12/04/13 - six times;
12/05/13 - five times;
12/06/13 - four times;
12/07/13 - six times;
12/08/13 - six times; and
12/09/13 - six times.

The documentation revealed between 11/25/13 and 12/09/13, the resident had not received the correct dose of oxycodone HCL six times.

On 12/11/13 at 10:45 a.m., CMA #5 was asked how often the resident was supposed to get routine pain medication. She stated, "When he is

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scheduled."

She was asked why had the resident not received pain medications as ordered on 11/25, 11/26, 11/27, 12/2, 12/3, 12/5 and 12/6. She stated, "Sometimes at night I don't wake the resident for pain medications."

She was asked how the resident's pain could be controlled if his pain medications were not administered as ordered. CMA #5 made no comment.

4. The 12/2013 monthly physicians' orders for resident #44, documented, "...Novolog 100 unit/ml vial...8 units Sub -q three times daily before meals..."

On 12/09/13 at 3:29 p.m., the resident was to receive 8u of Novolog before the evening meal.

LPN #5 looked for the resident's insulin. She stated, "There isn't any insulin with his name on it." She went to the medication room and did not find the resident's insulin.

She stated, "You can ding me because he is a brittle diabetic and I don't want him to bottom out. I will use another resident's insulin.

The pharmacist stated, "No, I will get it [insulin] for you."

At 4:25 p.m., the pharmacist brought a bottle of Novolog insulin for the resident.

5. The 12/2013 monthly physicians' orders for resident #12, documented "...Humalog 100...use per sliding scale directions...

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FSBS 150 - 200 = 2 units Humalog
FSBS 201 - 250 = 4 units Humalog
FSBS 251 - 300 = 6 units Humalog
FSBS 301 - 350 = 8 units Humalog
FSBS 351 - 400 = 10 units Humalog..."

On 12/10/13 at 10:07 a.m., CMA #3 was observed as she performed FSBS on resident #12. The resident's FSBS was 165.

LPN #5 stated, "I have to look for the rest of insulin in there [medication room]. She looked in the medication room and stated, "I don't have for the resident in the medication room. Sorry, but I've been off for a week." She told the resident he would have to wait for insulin before she could give his shot.

6. Resident #25 was admitted to the facility on 11/11/13 with diagnoses that included subarachnoid hemorrhage and chronic kidney disease stage IV.

A lab report, dated 11/12/13, documented, "...nasal culture...positive for MRSA..."

A physician's order, dated 11/14/13, documented, "...bactroban to both nares bid x 3 d..."

A medication administration record, dated 11/2013, documented the resident received the first dose of bactroban at 9:00 a.m. on 11/16/13.

A physician's order, dated 11/18/13, documented, "...vosal ear gtts use as directed..."

The medication administration record, dated 11/2013, documented the resident received the

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F 425	Continued From page 144 first dose of vosol ear drops on 11/21/13 at 12:00 p.m. A 14 day assessment, dated 11/25/13, documented the resident was cognitively intact, needed limited assistance with ADLs, and was always continent. On 12/16/13 at 10:00 a.m., the DON was asked who was responsible for ensuring medications were ordered, received, and administered in a timely manner. She stated, "The CMAs. We've had a problem with this." The DON reviewed the resident's physician's orders and medication administration records. She was asked why the resident had not received his medications in a timely manner. She stated, "I don't know." 7. Resident #28 was admitted to the facility with diagnoses that included pressure ulcers, quadriplegia, muscle spasms, and neuropathy. A physician's order, dated 10/31/13, documented, "...Ultram 50 mg tablet 1 PO every 4 hours as needed x 60 days and renew. Dx: pain 1-5..." A physician's order, dated 10/31/13, documented, "...Ultram 50 mg tablet 2 PO every 4 hours as needed x 60 days and renew. Dx: pain 6-10..." A care plan, dated 10/31/13, documented, "Problem: Pain...a risk for increase in pain level, she has contractures, pressure ulcers, peripheral neuropathy...receives routine Neurontin, Dilaudid and prn Tramadol, Norco, and Morphine...Goal:...will receive her pain medication as ordered...Approaches: ...administer pain	F 425		

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medication, PRN and routine, as ordered, medication for pain not to be held or altered without physician order to do so..."

An admission assessment, dated 11/07/13, documented the resident had a BIMS score of 15. This score indicated the resident was independent with cognitive skills for daily decision making. The assessment also documented she required extensive assistance to total dependence in activities of daily living, had pain almost constantly, rated the pain intensity at an eight, and was admitted with one stage three pressure ulcer.

A medication administration record, dated 12/2013, documented the resident could receive one Ultram 50 mg for pain levels from 1 - 5 and two Ultram 50 mg for pain levels from 6 - 10. This was written as per physician orders.

Across the administration entry boxes for the two Ultram 50 mg for pain levels from 6 - 10, it was documented, "Duplicate."

On 12/16/13 at 9:05 a.m., the resident was asked if her pain was controlled. She stated, "Yesterday it wasn't. I had to have pain medications all day long to help because I had slacked off on taking them."

She was asked how her pain was at this time. She stated her pain radiated up her spine.

At 11:47 a.m., CMA #8 was asked why duplicate was written across the medication administration record on the Ultram 50 mg 2 PO every 4 hours as needed. She stated, "Because it was already written here."

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F 425	Continued From page 146 She was asked to look at the medication administration record and see that there were two different amounts and two different pain scales. She stated, "Yes, it is two different pain levels. I don't know why. You would have to ask CMA #6."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F431 1. The insulin was removed from the top of the medication and placed in a safe place under lock on 12/11/13. 2. All residents have the potential to be affected. All other medication was monitored to ensure that they were stored in a safe place. 3. All CMA's and nurses were inserviced by the pharmacy consultant to keep medications locked in a safe place at all times on 1/12/14. 4. Audits will be completed weekly x 4, monthly x 3 and as needed to ensure medications are inaccessible to residents. Results will be reviewed in the Quality Assurance meeting.	1/21/14

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F 431	Continued From page 147 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to keep insulin medication under direct observation of the nursing staff for two (SE and Center) of four medication carts observed during tour of the facility. This had the potential to affect 45 residents identified by the facility who received insulin. Findings: A facility policy on administering medications, dated 12/2012, documented, "...Safety of Medication Cart...During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide...It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed...No medications are kept on top of the cart...The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by..." On 12/11/13 at 5:25 a.m., during tour of the facility's southeast hall, a basket of insulin was observed unattended on top of the medication cart. At 5:29 a.m., LPN #1 returned to the cart. She was asked what the facility's policy was regarding insulin left out on the medication cart unattended. She stated, "I know you don't leave pills out.	F 431		

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F 431	Continued From page 148 There is no room in my cart for insulin." She stated the other three halls she had worked on did not store the insulin when the cart was unattended. At 5:44 a.m., during a tour of the central hall, a basket of insulin was observed unattended on top of the medication cart. At 5:46 a.m., RN #1 walked past the surveyor with juice in each hand and distributed the juice to residents in the dining room. She returned to the cart and was asked what the facility's policy was regarding insulin left out on the medication cart unattended. She stated, "I know they should be put in the cart but there is no room." She stated, "I never do [put the insulin up.] Most of these people don't have good eyesight." On 12/17/13 at 9:42 a.m., the DON was asked where insulins should be stored during the medication pass and when not in view of the nurse. She stated they should be locked in the cart. She was asked why insulin was left out on two of the medication carts. She stated, "I don't know."	F 431		
F 441 SS=E	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	F 441	F441 1. Resident #18s room was terminally cleaned on 12/11/13. Resident #30, 31 and 34 will be fed in a manner that prevents cross contamination. Resident #33 catheter bag and tubing was replaced. Resident #38 had oxygen tubing replaced on 12/17/13.	1/21/14

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F 441	Continued From page 149 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 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to: A. Provide colostomy care in a manner that prevented cross-contamination for two (#15 and #16) of four sampled residents with colostomies. The facility identified eight residents as having colostomies;	F 441	Resident # 5 was given a diabetic shoes on 12/13/13 to protect her foot. Resident #15 was provided a new colostomy bag. 2. All residents have the potential to be affected. CNA #1, CMA #7, CNA #9, LPN #4, CNA #4, CMA #1, MDS Coordinator #1, CNA #7 and LPN#8 were educated on infection control policies including washing of hands, bagging of linen and cross contamination. They were also educated on colostomy care, oxygen care and catheter care and maintenance on 1/20/14. 3. All staff was educated on infection control policies including washing of hands, bagging of linen and cross contamination. They were also educated on colostomy care, oxygen care and catheter care and maintenance on 1/20/14. 4.Audits in infection control policies, catheter care, O2 tubing, colostomy care, and handwashing will be completed weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance meeting.	

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F 441	Continued From page 150 B. Provide feeding assistance in a manner that prevented cross-contamination for three (#30, #31, and #34) of eleven residents who were observed being fed. The facility identified 17 residents as being dependent with eating; C. Prevent cross-contamination of surgical wounds for one (#5) of two sampled residents with surgical wounds. The facility identified ten residents with surgical wounds; D. Ensure infection control practices were instituted to prevent cross-contamination for one (#33) of two sampled residents with urinary catheters. The facility identified 18 residents as having urinary catheters; and E. Prevent cross-contamination with oxygen tubing for one (#38) of one sampled resident who was observed to be using oxygen therapy. Findings: The facility's policy on assistance with meals, dated 10/2009, documented, "...All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling..." 1. Resident #18 was admitted to the facility on 11/18/13 with diagnoses that included a stage III pressure ulcer and colostomy. On 12/11/13 at 5:03 a.m., a very strong smell of feces was noted from the hallway to be coming from the resident's room.	F 441		

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The resident's light was off and the surveyor entered the resident's room. The resident asked, "Ma'am, can you help me? My colostomy needs to be changed out, and I can't do it." The surveyor asked the resident if she had pushed her call button for assistance. The resident asked, "Where is it?" The call light was observed to be between the resident's mattress and the left upper side rail. It was out of the resident's reach. The call light was given to the resident, and she pushed the button. The resident was noted to have dried feces covering her left hand. The resident's gown and bed linens were covered with feces. The resident's abdomen was exposed and feces was noted to cover her abdomen.

At 5:08 a.m., CNA #1 entered the resident's room. The resident informed the CNA she required assistance with her colostomy. CNA #1 turned on the light. Liquid feces was puddled in the juncture of the resident's legs. The resident's urinary catheter tubing was in the feces. The colostomy bag was expanded with air and feces, and feces was noted to be draining between the skin and the seal of the colostomy bag.

CNA #1 removed the resident's soiled gown and the top sheet. She bundled them up, and without bagging the linens, left the room, went down the center hall, and placed them in the soiled linen hamper. She stopped at room #30 on the center hall and requested CMA #7's help.

At 5:16 a.m., CMA #7 entered the room to assist the resident and CNA #1. They began to clean the resident.

At 5:18 a.m., CMA #7 ungloved and left the

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F 441	Continued From page 152 resident's room. She did not wash her hands before leaving the room. CMA #7 returned to the room with a new colostomy bag. CNA #1 removed her gloves and left the room without washing her hands. She returned with clean linens, wipes, and trash can liners. CNA #1 and CMA #7 continued to clean the resident. At 5:25 a.m., the resident was repositioned in bed. Dried rings of liquid feces were noted on the resident's incontinent pad. CMA #7 took the resident's call light, which was stained with dried feces, and placed it over the oxygen concentrator. CMA #7 took off her gloves and left the room without washing her hands. Her gloves were visibly soiled with feces. At 5:28 a.m., CMA #7 returned to the room with more wipes. CMA #7 told CNA #1 feces was still coming out of the resident's colostomy. CNA #1 drained the colostomy into a trash can liner. Feces continued to come from the stoma, leaking onto the resident and the mattress. CNA #1 placed the liner into the trash can and wiped the feces from the mattress using a disposable wipe. CMA #7 and CNA #1 continued to clean the resident. The resident was repositioned and stains were noted on the resident's mattress. A large white stain was noted near the resident's head, on the left side of the mattress. At 5:44 a.m., CMA #7 told CNA #1 that she had to leave so that she could do her job. CNA #1 asked for the nurse to be notified that she needed help. CMA #7 removed her gloves, and without	F 441		

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washing her hands, left the room. CNA #1 began to give the resident a bed bath.

At approximately 6:00 a.m., CNA #1 gathered the soiled linens from the bed bath, placed them in a bag, and without washing her hands, left the room. She went down the center hall, placed the bag of soiled linens in the hamper, and went into room #52 and washed her hands.

CNA #1 was asked how long she had worked at the facility. She stated she had been there since August, 2013. She was asked if anyone had completed a skills competency check for her. She stated, "No." She stated she had worked on another hall with a person for one night and then came to the center hall and had worked independently.

2. On 12/17/13 at 7:55 a.m., resident #38 was observed being propelling to the dining room in his wheelchair.

CNA #9 followed behind, pushing the resident's portable oxygen tank. The oxygen cannula was attached to the tank and the cannula drug across the dining room with the nasal prongs prongs touching the floor the entire width of the dining room. CNA #9 picked the cannula up off the floor and proceeded to place the prongs in the resident's nares. The surveyor stopped the CNA and instructed her to obtain a clean cannula.

CNA #9 left the cannula attached to the tank and left the dining room.

At 8:00 a.m., LPN #4 approached the resident and began to place the cannula on the resident. The surveyor stopped the LPN and explain the

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situation. LPN #4 left the dining room and returned with a new cannula.

On 12/17/13 at 9:00 a.m., the DON was asked how she ensured her staff performed their duties following current standards of practice in infection control. She stated the educator worked with the staff, inservices were given, and compliance rounds were made throughout the day.

3. On 12/09/13 at 11:55 a.m., CNA #4 was observed preparing drinks for the noon meal for residents #30, #31, and #34. CNA #4 took a sleeve of Styrofoam cups, and removed three, placing her hand in each of the cups as she removed them.

After she poured thickened liquid in each cup, CNA #4 placed her hand over the cups' openings and placed them around the table.

At 12:00 p.m., CNA #4 re-arranged the cups on the table. She placed her hand over the cups' openings as she re-arranged them.

At 12:07 p.m., while feeding resident #30, CNA #4 picked the cup up, touching the rim of the cup and placing her hand over the opening.

On 12/17/13 at 9:33 a.m., the DON and administrator were asked who monitored the dining rooms. The DON stated there was a licensed staff member who was supposed to monitor each dining room and the dietary manager monitored sometimes.

The DON was asked who ensured the aides provided feeding assistance using current standards of practice in infection control. She

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F 441	Continued From page 155 stated, "The nurses." On 12/17/13 at 9:00 a.m., the DON was asked how she ensured staff followed infection control practices. She stated the nurse educator worked with staff, inservices were held on infection control topics, and compliance rounds were made throughout the day. 4. Resident #33 was admitted to the facility with diagnoses that included cerebral palsy, diabetes and neurgenic bladder. A laboratory report, dated 06/10/13, documented the resident was positive for MRSA and escherichia coli in his urine. A laboratory report, dated 07/03/13, documented the resident's urine was positive for proteus mirabilis. A laboratory report, dated 07/18/13, documented the resident's urine was positive for gram negative bacilli. A care plan, dated 09/12/13, documented, "...Problem: Supra pubic catheter...Observe for urinary tract infection... Problem: Infection:...has history of urinary tract infections is at risk for recurrent urinary tract infections...Observe for urinary tract infection..." A quarterly assessment, dated 11/28/13, documented the resident had a BIMS of three, which indicated the resident was severely impaired in daily decision making It was documented the resident needed extensive assistance with transfers and had an indwelling	F 441		

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F 441	Continued From page 156 urinary catheter. Throughout the survey, on 12/09/13 through 12/13/13 and 12/16/13 through 12/17/13, resident #33 was observed six times in his wheelchair with the urinary catheter tubing dragging on the floor. Staff was observed as they walked passed the resident or stopped and to talk to the resident when his indwelling catheter tubing was on the floor. The staff included the DON, the MDS coordinator #1, CMA #1, and LPN #8. On 12/17/13 at 8:12 a.m., was asked what was the correct placement of an indwelling catheter tubing when a resident used a wheelchair. She stated, "In the privacy bag." She was asked if the tubing should be on the floor. She stated, "No." At 8:14 a.m., LPN #4 was asked what the correct placement of an indwelling catheter tubing was when a resident used a wheelchair. She stated, " Wrap it in the wheelchair. It has a hook and make sure it is not touching floor." She was asked who was responsible for ensuring urinary catheter tubing did not touch the floor. She stated, "The CNAs when they get the resident up and throughout the day." She was asked what she would do if she saw urinary catheter tubing touching the floor. She stated, "I would take him to his room and get someone to help me fix it." At 8:18 a.m., CNA #7 was asked what the correct placement of urinary catheter tubing was when a resident used a wheelchair. She stated, "Place it	F 441		

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in the dignity bag, and the tubing is hooked on the wheelchair so not to touch the floor."

She was asked what she would do if she saw the urinary catheter tubing on the floor. She stated, "I would fix it. It only takes 30 seconds."

5. Resident #5 was admitted to the facility on 05/03/13 with diagnoses that included CVA, diabetes mellitus, and neuropathy.

A quarterly assessment, dated 09/23/13, documented the resident was cognitively independent, needed assistance with locomotion, and had a stage II pressure ulcer.

A care plan, dated 10/13/13, documented, "Problem:..She aslo [sic]
has an area on her right great toe, She is a diabetic, At risk for slow
healing...Approaches:..Cleanse Rt great toe c NS apply santyl [unreadable] thick corner c foam drsg...p cleansing Rt great toe c NS pat dry apply silvadine sulfa cream...

Problem:..skin breakdown...Approaches:..Heel boot R foot @ all times..."

On 12/10/13 at 8:25 a.m., resident #5's wound was observed on her right great toe. The wound was observed to be 1.2cm x 1.2cm x 0.2cm on the top of the toe with a pin size whole in the middle of the wound. The resident's right great toe, right foot, and left foot were red in color and swollen.

At 3:35 p.m., resident #5 was observed on the center hall as she propelled herself in her wheelchair using her right great toe.

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F 441	Continued From page 158 On 12/12/13 at 9:00 a.m., LPN #3 was asked how the resident propelled herself in the wheelchair. She stated the resident used her right foot and that toe. She stated, "I changed to a ABD pad to give her more padding for her right toe." At 9:20 a.m., the resident was observed leaving the smoking room. She propelled herself in the wheelchair using her right great toe. At 10:00 a.m., the resident's bandage on her right foot was observed. A nickel-sized pink spot that was surrounded by a tan area that was approximately 1/2 inch round was observed on top of the dressing. On 12/12/13 at 5:32 p.m., LPN #3 was asked what interventions were implemented to aid in the prevention of cross-contamination with the resident's right great toe wound. She stated, "I just rewrapped the whole foot." She stated the spot on the dressing had been from the floor, not the wound. She was asked if the wound had been cultured. She stated no. At 5:36 p.m., the DON was asked what interventions were instituted to prevent cross-contamination with the resident's wound. She stated, "A boot but that caused a rubbing on other areas and we talked to the resident about physical therapy to lower her wheelchair." She was asked if it was documented. She stated, "I don't know." On 12/13/13 at 1:44 p.m., LPN #3 was asked to remove the bandage to see if there was any drainage from the wound. A quarter-sized area of	F 441		

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serosanquinous drainage was observed on the inside and outside of the bandage.

6. Resident #15 was admitted to the facility on 08/09/13 with diagnoses that included multiple sclerosis, muscular disuse atrophy, paraplegia, and colostomy.

A facility form, labeled skin and dated 10/10/13, documented, "...Colostomy care [every] shift per protocol...Frequency: 7-3; 3-11; 11-7..."

A quarterly assessment, dated 11/06/13, documented the resident was cognitively intact and was totally dependent on staff for transfer, toilet use, and bathing. Bowel continence documented, "...Appliances: ostomy..."

On 12/16/13 at 2:33 p.m., resident #15 was asked who usually did her colostomy care. She stated, "A lot of them try." She stated the colostomy bag was always to large for her stoma. She stated, "I try to tell them."

She was asked when the staff provided colostomy care. She stated, "When I start griping." She stated the staff does not rinse the colostomy bag after emptying it. She stated the staff wiped out the end of the bag with a "baby wipe."

At 2:45 p.m., resident #15's colostomy bag was observed to have a moderate amount of formed stool and air in the bag. The colostomy bag had a copious amount of feces lining the inside of the bag to the very end which was folded over once and clipped. Approximately one inch of the end of the bag was exposed past the clip. The bag's

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F 441	Continued From page 160 end that had been left exposed had not been cleansed of feces and was positioned next to the resident's skin. The bag's end was stuck together with dried feces. She was asked if the colostomy bag was usually folded once with the end exposed with feces and placed next to her skin after staff had emptied the bag. She stated, "Yes. I've had it drip down my side." She stated feces often gets on her clothes. On 12/17/13 at 9:18 a.m., the DON was asked what training the CNAs received on colostomy bags. She stated, "I need to look into that." She was asked how they were taught to clean the colostomy bag. She stated, "We just know to rinse with soap and water. She was asked who was responsible for changing the colostomy bag. She stated the nurses helped the CNAs, unless the nurse had instructed the CNA on the procedure.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain clean geriatric chairs for three (#30, #31, and #34) of four sampled residents who were	F 465	F465 1. Resident #30, #31 and #34 geri chairs were cleaned on 12/17/13. 2. All residents who used geri chairs have the potential to be affected. All other resident equipment was observed and cleaned if needed. 3. CNA's were inserviced on the equipment cleaning schedule on 1/3/14.	1/31/14

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F 465	Continued From page 161 observed to use geriatric chairs. The facility identified 12 residents as using geriatric chairs. Findings: The facility's policy and procedure on cleaning of equipment, dated 06/28/11, documented, "...To ensure that all equipment remains clean for dignity and cleanliness purposes...11-7 CNA's on all halls to clean geri-chairs Tuesdays and Saturdays...All nurses are to ensure that this is done; audits will be randomly [sic] by administration to ensure that this is completed...All mobility equipment including bottom of geri chairs and under seats to be washed with soap and water..." On 12/09/13 at approximately 10:30 a.m., a note was observed on the bulletin board at the north hall nurses' station. The note documented, "...11-7 is also responsible for cleaning wheelchairs and geri chairs. Below is the schedule for each hall...North Hall - Even # rooms on Tuesday[,] Odd # rooms on Wednesday..." On 12/09/13 at 12:00 p.m., the geriatric chair for resident #34 was observed to have multiple stains, dirt, dust, and debris on the back of the chair and the back of the seat. At 12:05 p.m., the geriatric chair for resident #30 was observed to be dirty. There were stains on the back of the seat and a build-up of dust and debris on the frame and wheels of the chair. At 12:11 p.m., the geriatric chair for resident #31 was observed to have stain on the back of the seat and a build-up of dust and debris on the frame and wheels of the chair.	F 465	4. Audits will be conducted to ensure resident equipment is clean, weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	

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F 465	Continued From page 162 From 12/09/13 through 12/13/13 and 12/16/17, the geriatric chairs remained stained and with dust and debris build-up. On 12/16/13 at 12:30 p.m., the corporate nurse was shown the geriatric chairs. She was asked what the stains were. She stated she was unsure. She was asked if the chairs were clean. She stated, "No." On 12/17/13 at 9:43 a.m., the administrator was asked who was responsible for cleaning resident equipment. She stated the nurse aides were. She was asked what the cleaning schedule was. She stated it was posted on the night shift. She stated the cleaning of geriatric chairs and wheelchairs was rotated. The administrator was asked who monitored to ensure the equipment was clean. She stated the infection control nurse did weekly audits. When asked why the geriatric chairs were dirty, the administrator stated, "They were just missed."	F 465		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have an effective pest control system for roaches at the facility. This had the potential to affect 163	F 469	F469 1. The facilities pest control company came to the facility and sprayed for bugs on 12/9/13. 2. All residents have the potential to be affected. The pest control log was reviewed to identify areas of greatest concern. 3. All staff was in-serviced on the pest control log and documenting areas of concern on 1/20/14.	1/31/14

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F 469	Continued From page 163 of 163 residents who resided at the facility. Findings: The facility's policy on pest control, dated 06/2006, documented, "...This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents..." Service request logs, dated 11/07/12 through 01/17/13, documented thirteen complaints of roaches. It was documented roaches were observed in rooms 29, 31, 35, 44, 48, and 50. It was also documented roaches were observed at the center nursing station, kitchen, dining room, and southwest nursing station. It was documented the whole building was sprayed on 01/02/13. Service request logs, dated 01/17/13 through 02/05/13, documented fourteen complaints of roaches. It was documented roaches were observed in the center dining room, medical records, center hall bath, kitchen, and rooms 31, 35, 36, 40, 42, 44, 48, and 50. Service request logs, dated 02/06/13 through 05/22/13, documented eleven complaints of roaches. It was documented roaches were observed in rooms 6, 24, 31, 38, 40, 48, and 50. It was documented roaches were observed in the kitchen, medical records, by the ice machine, center medication room, and center medication room. A comment, dated 02/06/13, documented, "...roaches in rm 48 everywhere..." Service request logs, dated 05/29/13 through 07/20/13, documented nine complaints of roaches. It was documented roaches were observed in rooms 29, 38, 44, and 50. It was	F 469	4. Audits will be completed to ensure the facility is free of pest weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	

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documented roaches were observed in the offices around the center nursing station. A comment, dated 05/29/13, documented, "...This building is full of cockroaches..." A comment, dated 07/20/13, documented, "...roaches crawling on floor night stand not just one..."

Service request logs, dated 07/20/13 through 10/28/13, documented ten complaints of roaches. It was documented roaches were observed in rooms 1, 30, 31, 33, 36, 49, and 50.

Resident council meeting minutes, dated 10/24/13, documented, "...Several rooms need to be sprayed for bugs. List will be given to [maintenance supervisor]..."

Service request logs, dated 11/05/13 through 12/09/13, documented nine complaints of roaches. It was documented roaches were observed in rooms 2, 33, 37, 40, and 50. It was documented roaches were observed in the center dining room. A comment, dated 11/12/13, documented, "...Rm 40 - all over..." A comment, dated 12/09/13, documented,"...Extreme roaches...closet side table w/c [room] 40A..."

On 12/09/13 at 10:15 a.m., resident #26 was asked if he had observed roaches in the building. He stated, "Yes." He stated he had told staff of the roaches.

On 12/09/13 at 11:52 a.m., the surveyor was seated at a table in the center hall dining room. A roach was observed to climb up the wall near the surveyor.

On 12/10/13 at 3:30 p.m., resident #47 approached the surveyor and stated, "Please

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F 469	Continued From page 165 take care of the cockroach problem." She was asked where she had observed roaches. She stated, "In my room, everywhere. They can't control the problem. They've been here since I entered the facility." She was asked how long she had been at the facility. She stated, "Almost a year." On 12/11/13 at approximately 9:15 a.m., the surveyor was in the center hall dining room, seated next to the microwave. One roach was observed crawling out from underneath the resident's microwave. On 12/16/13 at approximately 4:00 p.m., maintenance was asked to provide receipts of when the building had been treated for roaches. Receipts were provided that documented the facility had monthly treatments for roaches from 01/2013 through 12/2013. There were no receipts provided for any additional roach treatments until 12/09/13 when a different pest control company treated the facility for roaches. On 12/17/13 at 11:09 a.m., the administrator and maintenance supervisor were asked how often pest control came to the facility. The maintenance supervisor stated, "Once a month unless called for extra." The maintenance supervisor was asked how effective the treatments had been. He stated, "Have to stay on it all the time." They were asked what they had done about the ineffective treatments for roaches. The administrator stated they had just used another pest control company along with the regular company.	F 469		

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F 469	Continued From page 166 They were asked how long there had been a roach problem at the facility. The maintenance supervisor stated, "I really don't know. It comes in spurts. We call the exterminator every time we get a complaint."	F 469		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure CNAs were trained to provide colostomy care for two (#15 and #18) of four sampled residents with colostomies. The facility identified eight residents as having colostomies. Findings: 1. Resident #18 was admitted to the facility on 11/18/13 with diagnoses that included a stage III pressure ulcer and colostomy. On 12/11/13 at 5:03 a.m., a very strong smell of feces was noted from the hallway to be coming from the resident's room. The resident's light was off and the surveyor entered the resident's room. The resident asked, "Ma'am, can you help me? My colostomy needs to be changed out, and I can't do it." The surveyor asked the resident if she had pushed	F 498	F498 1. Resident #18s room was terminally cleaned on 12/11/13. Resident #15s colostomy bag was replaced on 12/11/13. 2. All residents have the potential to be affected. All other residents with catheter bags were assessed on 12/11/13 to determine the need for assistance or care. 3. All staff was inserviced on infection control and colostomy care on 1/20/14. 4. Audits will be completed on colostomy care weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/21/14

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F 498	Continued From page 167 her call button for assistance. The resident asked, "Where is it?" The call light was observed to be between the resident's mattress and the left upper side rail. It was out of the resident's reach. The call light was given to the resident, and she pushed the button. The resident was noted to have dried feces covering her left hand. The resident's gown and bed linens were covered with feces. The resident's abdomen was exposed and feces was noted to cover her abdomen. At 5:08 a.m., CNA #1 entered the resident's room. The resident informed the CNA she required assistance with her colostomy. CNA #1 turned on the light. Liquid feces was puddled in the juncture of the resident's legs. The resident's urinary catheter tubing was in the feces. The colostomy bag was expanded with air and feces, and feces was noted to be draining between the skin and the seal of the colostomy bag. CNA #1 removed the resident's soiled gown and the top sheet. She bundled them up, and without bagging the linens, left the room, went down the center hall, and placed them in the soiled linen hamper. She stopped at room #30 on the center hall and requested CMA #7's help. CNA #1 told CMA #7 the resident's colostomy had burst. The surveyor asked CNA #1 if the bag burst or was it full. CNA #1 stated, "It's full. It's coming out." CNA #1 was asked how often she checked on the resident. She stated, "Every two hours." She was asked when the resident was checked last. She stated, "I don't know the exact time. Between 3:00 and 3:30 [a.m.]." CNA #1 was asked if she checked the resident's colostomy bag., She stated, "No, I didn't." She stated, "When I come in I check the bags and	F 498		

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F 498	Continued From page 168 colostomy." CNA #1 was asked when she started her shift. She stated 11:00 p.m. She was asked when she emptied the colostomy. She stated at the beginning and end of her shift. At 5:16 a.m., CMA #7 entered the room to assist the resident and CNA #1. They began to clean the resident. At 5:18 a.m., CMA #7 ungloved and left the resident's room. She did not wash her hands before leaving the room. At 5:19 a.m., CMA #7 returned to the room with a new colostomy bag. CNA #1 stated every where else she had worked, the nurses changed the colostomy bags. The colostomy bag was placed on the overbed table. At 5:20 a.m., CNA #1 removed her gloves and left the room without washing her hands. She returned at 5:22 a.m. with clean linens, wipes, and trash can liners. CNA #1 and CMA #7 continued to clean the resident. At 5:25 a.m., the resident was repositioned in bed. Dried rings of liquid feces were noted on the resident's incontinent pad. CMA #7 took the resident's call light, which was stained with dried feces, and placed it over the oxygen concentrator. CMA #7 took off her gloves and left the room without washing her hands. Her gloves were visibly soiled with feces. At 5:28 a.m., CMA #7 returned to the room with more wipes. CMA #7 told CNA #1 feces was still coming out of the resident's colostomy. CNA #1 drained the colostomy into a trash can liner. Feces continued to come from the stoma, leaking	F 498		

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onto the resident and the mattress. CNA #1 placed the liner into the trash can and wiped the feces from the mattress using a disposable wipe. CMA #7 and CNA #1 continued to clean the resident.

The resident was repositioned and stains were noted on the resident's mattress. A large white stain was noted near the resident's head, on the left side of the mattress.

At 5:44 a.m., CMA #7 told CNA #1 that she had to leave so that she could do her job. CNA #1 asked for the nurse to be notified that she needed help. CMA #7 removed her gloves, and without washing her hands, left the room. CNA #1 began to give the resident a bed bath. The surveyor left the room.

At 5:58 a.m., the surveyor returned to the room. CNA #1 was observed to be finishing placing the new colostomy bag on the resident. CNA #1 gathered the soiled linens from the bed bath, placed them in a bag, and without washing her hands, left the room. She went down the center hall, placed the bag of soiled linens in the hamper, and went into room #52 and washed her hands.

CNA #1 was asked how long she had worked at the facility. She stated she had been there since August, 2013. She was asked if anyone had completed a skills competency check for her. She stated, "No." She stated she had worked on another hall with a person for one night and then came to the center hall and had worked independently.

CNA #1 was asked if she had put the new

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colostomy bag on the resident. She stated, "Yes." She was asked if she had been trained to replace colostomy bags. She stated, "No. That was my first one ever." CNA #1 was asked if there was enough staff on her shift to meet the residents' needs. She stated, "Usually. That's the worst thing that's happened. I was trying to get people up and that consumed all my time. The resident had to wait."

On 12/12/13 at approximately 8:30 a.m., the corporate nurse stated she had reviewed the cameras. She stated the aide had been in the resident's room seven times during her shift. The corporate nurse provided documentation of the times the CNA had entered the room. The time the CNA spent in the room on each visit ranged from two to six minutes. It was documented another staff member, either an RN or CMA, entered the room at 4:44 a.m. and spent 12 minutes in the room.

The surveyor explained the aide had stated she had not checked the resident's colostomy bag since the beginning of the shift. The corporate nurse stated the resident had ate beans and cabbage for the previous evening meal, causing increased gas. She stated some nursing homes did not check the colostomy bags but once per shift.

On 12/17/13 at 9:14 a.m., the DON was asked how often the CNAs were checked for proficiency. She stated, "Monthly." She was asked how the checks were completed. She stated there were either monthly or quarterly skills check offs completed. She stated the checks were completed by the nurse educator and ADON. The DON was asked if the CNAs were

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checked for proficiency before working independently. She stated, "Yes."

The DON was asked what training the aides received regarding colostomy bags. She stated, "I need to look into that, They are trained to empty every shift."

She was asked how the staff would know if the resident had gas-causing foods. She stated the menu was documented on the board by the nurses' station. She was asked what staff was expected to do if they knew a resident had consumed gas producing food. She stated they should check the colostomy more often.

The DON was asked who was responsible for changing the bag. She stated, "The nurse helps the CNA unless the nurse has instructed the CNA on how to do it."

On 12/17/13 at approximately 3:00 p.m., a copy of the competency checklist for CNA #1 was provided to the surveyor. The checklist did not include colostomy care or replacing colostomy bags.

2. Resident #15 was admitted to the facility on 08/09/13 with diagnoses that included multiple sclerosis, muscular disuse atrophy, paraplegia, and colostomy.

The resident's care plan, dated 08/09/13, documented, "...Problem. .Colostomy functioning without difficulty...Skin intact..."

The approaches did not include rinsing the colostomy bag after emptying or proper folding and clipping the end of the bag to prevent

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leakage of feces onto the resident's skin in order to maintain skin integrity.

A facility form, labeled skin and dated 10/10/13, documented, "...Colostomy care [every] shift per protocol...Frequency: 7-3; 3-11; 11-7..."

A quarterly assessment, dated 11/06/13, documented the resident was cognitively intact and was totally dependent on staff for transfer, toilet use, and bathing. Bowel continence documented, "...Appliances: ostomy..."

On 12/16/13 at 2:33 p.m., resident #15 was asked who was responsible for emptying her colostomy bag. She stated, "A lot of them try." She stated the staff did not rinse the colostomy bag after emptying it. She stated staff sometimes used a "baby wipe" to clean inside the end of the bag.

At 2:45 p.m., resident #15's colostomy bag was observed to have a moderate amount of formed stool and air in the bag. The colostomy bag had a copious amount of feces lining the inside of the bag to the very end which was folded over once and clipped. Approximately one inch of the end of the bag was exposed past the clip. The bag's end that had been left exposed had not been cleansed of feces. The bag's end was stuck together with dried feces.

She was asked if the colostomy bag was usually folded once with the end exposed with feces after staff has emptied it. She stated, "Yes. I've had it drip down my side." She stated feces often got on her clothes.

On 12/17/13 at 9:18 a.m., the DON was asked

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F 498	Continued From page 173 what training the CNAs received on colostomy bags. She stated, "I need to look into that." She was asked how they were taught to clean the colostomy bag. She stated, "We just know to rinse with soap and water."	F 498		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to obtain laboratory tests as ordered by the physician for one (#20) of 29 sampled residents whose clinical records were reviewed. The facility identified 122 residents as having physician orders for laboratory tests. Findings: Resident #20 was admitted to the facility on 07/01/10 with diagnoses that included end-stage renal disease. A physician's order, dated 09/17/13 at 1:30 p.m., documented the resident was to receive Lovenox, a blood thinner, 60 mg subcutaneously every twelve hours. Another physician's order, dated 09/17/13 at 1:30 p.m., documented the resident was to receive Coumadin, a blood thinner, 5 mg every day, starting 24 hours after the Lovenox was started. It was ordered the resident was to receive an INR	F 502	F502 1. Resident #20s INR was d/c'd on 9/26/13. 2. All residents who have lab work ordered have the potential to be affected. A review of all labs ordered was completed on 1/9/14 to ensure they were obtained and the results were on the chart. 3. All staff was inserviced on completing labs as ordered on 1/20/14. 4. Audits will be conducted to ensure labs are completed weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance meeting.	1/21/14

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(International Normalization Ratio) lab test every day.

Review of the clinical record revealed no documentation the INR lab test was done.

A physician's order, dated 09/17/13 at 1:45 p.m., documented, "...ultrasound [left] arm dx thromboflabitis [sic]..."

An ultrasound result, dated 09/17/13, documented, "...Duplex examination left upper extremity veins...Findings: Normal augmentation and compressibility within the left upper extremity veins. No evidence for DVT..."

Review of medication administration records, dated 09/2013, documented the resident did not receive the first dose of Lovenox until 6:00 p.m. on 09/18/13.

A nurse's note, dated 09/19/13 a 6:00 p.m., documented, "...Lovenox 60 mg sq bid. To start Coumadin 5 mg po tonight..."

Review of medication administration records, dated 09/19/13, revealed the resident received a dose of Coumadin at 6:00 p.m..

A physician's order, dated 09/20/13 at 1:00 p.m., documented, "...dc Coumadin 5 mg po qd, dc Lovenox 50 mg sq..."

A physician's order, dated 09/26/13, documented, "...DC daily INRs..."

On 12/12/13 at 10:00 a.m., medical records was asked for the INR lab results.

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F 502	Continued From page 175 At 5:45 p.m., the corporate nurse was asked to provide the lab results. She stated medical records could not find the results. She was asked if she could access the results via computer. She stated, "No." The DON was asked if she could access the results via computer. She stated, "No." She stated the quality assurance nurse was "working on it." At 5:50 p.m., the quality assurance nurse stated she could access results but could not access the orders for the lab tests. At 5:55 p.m., the corporate nurse stated there was no order in the computer for the INRs, and there were no results. The corporate nurse stated CMA #9 would be back the following day and since he was responsible for ordering labs, he would need to be interviewed. On 12/13/13 at 10:00 a.m., CMA #9 was asked if he ordered the INRs as ordered by the physician. He stated, "No." He was asked why he did not order the tests. He stated the ultrasound test had been reported to be negative the day the order was received and he told the nurse of the results. He stated, "So, I didn't put it in." CMA #9 was asked if there had been a physician's order to discontinue the INR tests. He stated, "Not that day." He was asked if the medications were given. He stated, "Don't know. I got the dc order later."	F 502		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical	F 507	F507 1. Resident #8 lab results were placed in the clinical record on 12/19/14.	1/31/14

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F 507	Continued From page 176 record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure laboratory test results were filed in the clinical record for one (#8) of 29 residents whose laboratory test results were reviewed. The facility identified 122 residents as having physician orders for laboratory tests. Findings: Resident #8 was admitted to the facility on 05/08/13 with diagnoses that included hypothyroidism. Physician's orders, dated 11/2013, documented the resident was to have a thyroid stimulation hormone level test completed twice yearly in October and April. Review of the clinical record revealed no documentation the test had been completed in October. On 12/10/13 at 2:00 p.m., the quality assurance nurse was asked where the lab result was. She stated it should be in the clinical record. She reviewed the clinical record and stated the lab was not there. The quality assurance nurse stated LPN #8 made copies of labs for the infection control log and the night nurses were supposed to put the copies on the chart. The quality assurance nurse was asked if the lab results were being placed on the	F 507	2. All resident who have received lab work have the potential to be affected. A review of all labs ordered was completed on 1/9/14 to ensure they were obtained and the results were on the chart. 3. All staff was inserviced on completing labs as ordered and filing in the clinical record on 1/20/14 4. Audits will be conducted to ensure labs are completed and results on the chart weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance meeting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 507	Continued From page 177 record. She stated, "Apparently not." On 12/10/13 at 3:00 p.m., the facility provided the results of the laboratory test.	F 507		
F 514 SS=E	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: Based on interview and record review, it was determined the facility failed to have accurate and complete clinical records for one (#28) of 29 sample residents whose clinical records were reviewed. This had the potential to affect 163 residents who resided at the facility. Findings: 1. Resident #28 was admitted to the facility with diagnoses that included pressure ulcers, quadriplegia, muscle spasms, and neuropathy. A care plan, dated 10/31/13, documented, "...Problem: Pressure ulcers...admitted with	F 514	F514 1. Resident # 28s documentation from the wound care clinic was placed in her clinical record. 2. All residents who reside in the facility have the potential to be affected. Chart audits were completed to ensure that medical records were complete and accurate. 3. All staff was inserviced on filing progress notes in the clinical record on 1/20/14. 4. Audits will be completed to ensure clinical records are complete and accurate weekly x 4, monthly x 3 and as needed. Results will be reviewed in the Quality Assurance Meeting.	1/21/14

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pressure wounds on coccyx, buttocks, & bil. heels. She has a wound vac...Stage 3 pressure wound to coccyx, buttocks...Goal: ...will receive treatments as ordered and minimize her risk for increase in pressure sores...Approaches: wound nurse to assess pressure ulcer for size, depth and color and document on weekly wound tracking sheet...wound vac in place per physician orders, dressing changes 3 x wk..."

An admission assessment, dated 11/07/13, documented the resident had a BIMS score of 15. This score indicated the resident was independent with cognitive skills for daily decision making. The assessment also documented she required extensive assistance to total dependence in activities of daily living, had pain almost constantly, rated the pain intensity at an eight, and was admitted with one stage three pressure ulcer.

A [hospital name withheld] wound center progress note, dated 11/18/13, documented, "...Return appointment in 2 weeks...Pressure ulcer III/IV - left hip - start dakins wet to dry dressing until wound vac approved. rt hip - medihoney and foam 3x/wk..."

An updated pressure ulcer care plan, dated 12/03/13, documented, "R hip wound - clean c NS, pat dry, apply medihoney & cover c foam M-W-F & prn...L ischial - clean c NS, pat dry, apply black foam & track as indicated & apply NPWT @ 125 mmHg - [change] M-W-F & prn...R great toe - clean c NS, pat dry, apply medihoney to wound, cover c ABD pad, secure c gauze - [change] qd & prn..."

A TAR, dated 12/2013, documented dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375034	A. BUILDING ______ B. WING ______	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	6202 EAST 61ST STREET TULSA, OK 74136

(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
F 514	Continued From page 179	F 514		

changes for the three wounds to be changed Monday, Wednesday, Friday, and pm on the 7-3 shift. Signatures for dressing changes were not documented for the left buttock wound vacuum on 12/04/13, 12/09/13, and 12/13/13. Signatures for dressing changes were not documented for the right hip on 12/02/13, 12/04/13, 12/09/13, and 12/13/13. Signatures for dressing changes were not documented for the right great toe on 12/04/13, 12/06/13, 12/09/13, and 12/13/13.

A [hospital] wound center progress note, dated 12/02/13, documented, "...chronic wound follow up: Tolerating treatment. Slowly contracting. Debridement as needed. Continue current treatment. Follow up - L ischial 3 0 depth. cultured R buttock medihoney 3 x week f/u 2 weeks Pressure ulcer III/IV..."

No documentation was provided for dressing changes being performed on 12/04/13 and 12/09/13.

A physician's progress note, dated 12/13/13, documented, "...rounding c wound care tx nurse, tolerated tx well...r buttock decub 3.3 x 2.7...L buttock III 4.5 x 1.5 x 1 cm...R digit 2 x 2 cm..."

On 12/16/13 at 9:30 a.m., LPN #9 was asked who performed the resident's wound care. She stated LPN #3 did the dressing changes.

At 9:45 a.m., LPN #3 was asked if she performed the wound care on the resident. She stated, "No, the skilled wounds are done by the nurses on the skilled unit. The skilled wounds have been a mess. There has been no consistent wound treatment nurse.

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F 514	Continued From page 180	F 514		

She was shown the TAR, and asked if no initials on the highlighted dates meant the dressing change had not been completed. She stated, "That's what that means, yes."

At 10:45 a.m., LPN #2 was observed performing wound care for the resident. The resident was scheduled for the wound clinic in the afternoon and the LPN removed the wound vacuum and placed a wet to dry dressing after cleaning and measuring the left buttock wound. She completed wound care to the right hip and right great toe as ordered.

On 12/16/13 at approximately 12:30 p.m., the DON and corporate nurse were asked why the pressure ulcer treatments had not been completed as ordered by the physician. They were informed of the dates where there was no documentation to show the treatments had been completed.

At approximately 2:00 p.m., the corporate nurse and DON stated the pressure ulcers treatments had been completed on Mondays at the wound clinic and on Fridays with the physician and wound nurse. They were asked to provide documentation.

At approximately 4:00 p.m., the corporate nurse and DON provided documentation to show the pressure ulcer treatments had been completed. When asked why the documentation was not in the clinical record, the corporate nurse stated it should have been.