STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. BUILDING _____ B. WING _____	03/27/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0221 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure one (Resident #6) of three residents reviewed for physical restraints were free from physical restraints imposed for purposes of convenience and not required to treat medical symptoms. Resident #6 had lap buddy restraint used when he was sat in a wheelchair to prevent him from rising from the wheelchair and falling. The resident was unable to remove the lap buddy at will or on request. No attempts had been made to reduce the restraint. This failure could affect six residents, including Resident #6, identified by the facility as being physically restrained and 142 residents with dementia, placing them at risk for being restrained for convenience and not required to treat medical symptoms, resulting in functional decline, depression and pressure ulcers. Findings included: Resident #6 ' s annual MDS resident assessment, dated 08/28/14, reflected he was a [AGE] year-old male with an admission date of [DATE], with [DIAGNOSES REDACTED]. The MDS assessment further reflected the resident used a chair that prevented rising as a restraint daily. Resident #6's most recent care plan, dated 08/21/14, reflected the lap buddy restraint was required due to Resident #6's confusion, unawareness of safety and trunk control. The goal to be accomplished from using the lap buddy was: 1) The resident would be free from complications related to restraint use, including contractures, skin breakdown, altered mental status, isolation or withdrawal through the review date of 07/31/14; 2) Restraint use would be minimized/eliminated by the review date of 07/31/14; and 3) Reassessment would occur every 30 days for restraint reduction program with a target date of 07/31/14. All three goals were implemented on 04/04/14. The care plan did not address a specific medical symptom the restraint was being used to treat. Interventions related to the restraint included provided restraint free time during activities with supervision, opportunities for restraint free time and physical activity daily, and evaluating continuing risks/benefits of the restraint, alternatives to the restraint and need for its ongoing use. A Restraint/Enabling Device/Safety Device Evaluation Assessment form, dated 09/12/14, reflected the medical condition that required a restraint was the resident's trunk control and unawareness of safety related to dementia. The assessment reflected a checklist of 25 possible options that could have been implemented as an before recommending the lap buddy; none of them had been checked off as tried except the lap buddy. The assessment listed the lap buddy as a restraint because the resident was not able to remove it on command. It further reflected the restraint enabled Resident #6 to maintain proper body positioning and increased his sense of safety and security. A Restraint/Enabling Device/Safety Device Evaluation Review form was completed on 01/03/15; no changes were recommended. Review of the clinical record indicated that monthly assessments were not being completed to assess the possibility of restraint reduction. The restraint was supposed to be minimized or eliminated 6 months prior to the survey, but remained in use. Resident #6 was observed on 03/22/15 at 2:17 PM, sitting in a wheelchair with a lap buddy, in a corner of the common area in front of the nurses' station. During this observation the weekend charge nurse, LVN L, described the resident as being totally dependent on staff for all ADLs ' s, being alert and oriented to person only, incontinent, confused and forgetful, and wearing an abdominal binder because he had pulled out his [DEVICE] within the past week. LVN L said Resident #6 had brain damage, was a fall risk, only understood his native language, and could only speak a few words. She stated there was no one on the weekend who could speak his language except for maybe housekeeping, but they were not always on the secured unit working. LVN L stated Resident #6 had a weak back and that was why he used a lap buddy. She attempted to ask Resident #6 to remove the lap buddy; however, he did not appear to understand and made no attempt to move it. LVN L stated Resident #6 had not had any falls since she had worked on the secured unit. Resident #6 was observed in a wheelchair with a lap buddy restraint secured to the front of the wheelchair during the following times: 1. 03/18/15 at 2:17 PM in the corner against a wall in the living area by the secured elevator. 2. 03/23/15 at 11:45 AM in the living area. 3. 03/23/15 at 12:50 PM in the dining room. 4. 03/23/15 at 3:50 PM in the corner of the living room by the secured elevator. 5. 03/24/15 at 12:40 PM in the dining room. 6. 03/24/15 at 1:10 PM in the living area. 7. 03/24/15 at 4:20 PM on the living area. 8. 03/24/15 at 5:05 PM in the living area. 9. 03/24/14 at 5:12 PM, lap buddy removed in resident's room for bolus feeding. 10. 03/25/15 at 9:13 AM in the dining room. 11. 03/25/15 at 2:15 PM in the living area. 12. 03/25/15 at 3:31 PM in the living area. An observation was made of Resident #6 continuously from 11:40 AM - 2:15 PM on 03/24/15. Resident #6 was in his wheelchair with his lap buddy on the entire time. During the meal observations on 03/23/15 (lunch), 03/24/15 (lunch), 03/25/15 (breakfast), 03/27/15 (breakfast), Resident #6 was observed to be assisted to the dining room via his wheelchair with his lap buddy on. An observation and interview with LVN N on 03/24/15 at 1:15 PM, revealed he had pushed Resident #6's wheelchair into the dining room. He said he did not walk the resident to the dining room for lunch that day because two of the staff were on their break, and he was just trying to get all the residents into the dining room. An observation was made of Resident #6 on 03/24/15 at 2:15 PM, revealed he was taken out of the dining room by a CNA in his wheelchair, not walked. An observation was made on 03/25/15 at 3:15 PM, indicated Resident #6 had a chair alarm affixed to his wheelchair that not been there the two days prior during the survey. The resident still had a lap buddy in place on his wheelchair. After surveyor intervention on 03/25/15 at 7:30 PM with the DON, ADM and ADON, the facility removed Resident #6 ' s lap buddy restraint and provided a 1:1 staff with him for the overnight shift and during the 6:00 AM - 2:00 PM shift the following day. Observation of Resident #6 on 03/26/15 at 10:10 AM, showed the resident in a wheelchair with a chair alarm and no lap buddy. He was not leaning from side-to-side nor did he appear to have any issues with trunk control. He had a large stuffed animal he was holding and dropped several times on the floor; yet he managed to pick it up from his wheelchair without appearing to be at risk of falling out. An observation of Resident #6 was made on 03/26/15 at 2:25 PM, with his lap buddy removed from his wheelchair and a chair alarm in place. The resident was observed to be kicking a ball with two CNAs, was laughing, smiling and engaged with the activity. He was able to hit and kick the ball a number of times. The CNAs stated the resident had not tried to get up from his wheelchair nor had he fallen. An interview with LVN N on 03/23/15 at 11:50 AM, revealed Resident #6 ambulated by walking, but needed assistance. He stated Resident #6 liked to get up from bed in the morning when he heard noise from the staff shift change. LVN N stated he put the resident in his wheelchair with his lap buddy while he did rounds on the floor at the beginning of his shift. LVN N said the resident had not tried to elope from the secured unit and had not fallen in the year he had worked on the secured unit. An interview with LVN M on 03/24/15 at 4:05 PM, revealed he did not walk the resident around the secured unit out of his wheelchair, and the only time his lap buddy was removed was during incontinent care. Interview was conducted with the 1:1 staff, MA O on 03/26/15 at 10:15 AM. She revealed Resident #6 had been in his wheelchair that morning without his lap buddy and did not try to get up, nor had he fallen. She stated she did not walk around with the resident every two hours because he required two staff to help him walk. She said he was unsteady and sometimes would try to sit down/crouch while walking. The facility's Restraint Policy dated May 2007 reflected, Each resident requiring a restraint shall have the restraint released frequently throughout the day. During this time, the resident should be re-positioned. The policy did not include any discussion regarding the facility being engaged in a systematic and gradual process toward reducing a resident ' s restraints. Form CMS-672, Resident Census and Conditions of Residents, signed by the DON on 03/22/15, reflected six

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

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F 0221 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) residents with physical restraints and 142 residents with dementia.

F 0248

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide activities to meet the interests and needs of each resident.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview and record review, it was determined the facility failed to provide an on-going activity program designed to meet the needs of the residents taking into consideration the resident's comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of two of 18 residents (Residents #5 and #6) reviewed for activities on one of three secured units. Residents #5 and #6 were not provided consistent daily and weekly activities, which were resident-oriented and cognitively appropriate. This failure could affect the 24 residents on one of three secured memory care units, including Residents #5 and Resident #6, placing them at risk for decreased self-esteem, isolation, decreased socialization, increase in behaviors and a decreased quality of life. Findings included: (1) Resident #6 was observed on 03/22/15 at 2:17 PM, sitting in a wheelchair with a lap buddy, in a corner of the common area in front of the nurses' station. During this observation, the weekend charge nurse, LVN L, described the resident as being totally dependent on staff for all ADLs, being alert and oriented to person only, incontinent, confused and forgetful. LVN L said Resident #6 had brain damage, was a fall risk, and only understood his native language, but could only speak a few words. She stated there was no one on the weekend who could speak his language except for maybe housekeeping, but they were not always on the secured unit working. LVN L stated Resident #6 had a weak back and that was why he used a lap buddy. She attempted to ask Resident #6 to remove the lap buddy; however, he did not appear to understand and made no attempt to move it. LVN L stated Resident #6 had not had any falls since she had worked on the secured unit. Resident #6 ' s annual MDS resident assessment, dated 08/28/14, reflected he was a [AGE] year-old male with an admission date of [DATE], with [DIAGNOSES REDACTED]. The MDS assessment further reflected the staff assessed the resident's preference in activities and concluded he liked showers, snacks, music, animals, groups and his favorite activities. Resident #6's most recent care plan, dated 08/21/14, reflected he should be provided restraint free time during activities when possible and to supervise closely. The care plan did not reflect any specific individual interests/activities Resident #6 liked and would be able to participate in. The care plan did not address his communication status in relationship to how he was able to be involved in activities. An observation was made of Resident #6 occurred on the secured unit on 03/23/15 at 3:50 PM. Resident #6 was in his wheelchair with a lap buddy, in the corner of the room. The assistant AD was in the living area conducting an exercise activity with some of the residents. He was not engaged in the activity going on with the other residents; he was not sitting near any other residents. An observation of Resident #6 occurred on 03/24/15 at 1:10 PM, after lunch, revealed he was wheeled into the living area by a staff and placed with his back facing away from the television. None of the residents in the living area were engaged or watching the television. About 8 residents were in a Geri-chair lined up in front of the television, but were not looking at it; about six residents were sitting in chairs against the wall in the living room, asleep or gazing off. The volume on the television was not turned up sufficiently for anyone to hear, and it was too small for residents in certain areas of the living room to see. An observation was made on 03/25/15 at 3:31 PM, at a karaoke sing-a-long on the secured unit, Resident #6 was in the living room, but not engaged in the activity. An interview with MA T on 03/24/15 at 1:45 PM, revealed Resident #6 liked music and when he heard it, he would often start dancing. MA T said some of the staff would play music for him through their personal phones. She said they did not play it on the radio in the living room because the other residents may not have liked it. She said Resident #6 did say a few words in his language and she talked to him in his language. She did not think there was anyone else on the secured unit who was fluent in his language. CMA T said the only DVD player on the secured floor in the living area was broken and the antennae was missing from the large stereo system so music on the radio could not be heard, only available CDs. An interview with CNA RR on 03/25/15 at 2:33 PM, revealed the residents really enjoyed any music activity, especially live music. She said they also liked classic black and white movies. Regarding Resident #6, CNA RR said he seemed to respond to soccer on TV and sometimes she would take him to his room and put it on his television. (2) Resident #5's significant change MDS Assessment, dated 03/06/15, reflected she was an [AGE] year-old female who admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The
MDS assessment reflected the staff's assessment of Resident #5's preferred activities, which were showers, snacks, and groups. Resident #5's most recent care plan, dated 03/12/15, reflected she was at risk for depression and the intervention was to administer medications as ordered. Her care plan did not reflect any discussion related to activities. The only care plan conference summaries available dated 05/14/14 and 11/13/14 reflected under the Care Plan Element of the form, that Resident #5, In common area with peers frequently. Resident #5 was initially observed during rounds on 03/22/15 at 3:53 PM, lying in a Geri-chair in the living area. During this observation, LVN L described the resident as being totally dependent on staff for all ADLs, was alert and orient to person only, incontinent, confused, had crying spells, a [DIAGNOSES REDACTED]. Resident #5 was crying during the observation in her geri-chair. An interview with MA T on 03/23/15 at 3:55 PM, revealed the Assistant AD had been doing the exercise activity for about 15-20 minutes and then left the secured unit. She did not know why she left. She stated earlier that morning, some of the residents sat a table and folded a towel as an activity. An interview with CNA WW on 03/24/15 at 1:40 PM, revealed she had been at work since 8:00 AM, and normally provided showers for the residents. She said she did not recall any activities being done with the residents during her shift. She stated a lady would sometimes come up to the floor and did a kick ball exercise. An interview with LVN N on 03/24/15 at 1:55 PM, revealed Resident #5's medications were being increased because she had more frequent crying spells. He said she used to be a homemaker and cooked a lot so sometimes the staff would try to ask her how to make a recipe and her mood improved. He stated there were no cooking activities offered on the secured unit, they were downstairs on the main floor in the activity room. He said only residents who could follow directions could go, not Resident #5. A confidential interview with a resident revealed he/she asked if the exercise activity was occurring because the State was in the building inspecting the facility. He/she said the residents on the secured unit usually did not do any activities and normally just stayed in the living area rocking back and forth, sitting and crying. He/she said the exercise activity that had been going on that day was unusual. A confidential family interview revealed he/she did not see a lot of activities take place on the secured unit. He/she said the residents were usually just put in their wheelchairs or Geri-chairs, some were lined up against the wall and some were lined up in a circle. He/she said they were often just sitting there. He/she said sometimes the television was on, but no one watched it. He/she said they knew the secured unit was not very good and were thinking about moving their loved one off the unit. A confidential interview with a resident, revealed there were not a lot of activities on the secured unit and most of the residents just slept. He/she said people sometimes came and played the piano, but the loudness of the music sometimes upset the residents. An observation was made on 03/25/15 at 2:12 PM reflected a bulletin board for daily activities for the week was changed from the schedule posted the day before. It reflected, 3/25/15 Wednesday 10:45 AM Storytelling, 11:30 AM Creative Paint, 12:00 PM Music, 1:30 PM Bingo (Auditorium) and 3/26/15 Thursday 10:45 AM Beauty Care, 3:00 PM Exercise, and 3:30 PM Sing-a long. An interview with CNA TT on 03/25/15 at 2:25 PM, revealed there was nothing planned for activities that afternoon. She hoped the assistant AD was going to make it back up to the secured unit that afternoon. CNA TT said the large stereo was broken and she had to use a small one from the staff break room. She said the residents really liked music. She went and put on some oldies music but the television was still on at a volume that coincided with the sound of the music. An observation was made on 03/26/15 PM at 10:10 AM, of a drawing activity with six residents at the table in the living room. Resident #6 was in his wheelchair holding a large stuffed dog, away from the activity. Resident #5 was lying in her Geri-chair facing away from the activity. Neither residents were involved in the activity nor were they being engaged by the activity director or staff. An interview with the CRD on 03/26/15 at 10:49 AM, occurred wherein she was asked to locate any activity assessments or progress notes completed for Residents #5 and #6. She looked on the e-chart and could not locate them. She stated they may have been on the hard chart and would go check. The only Activity Note available in Resident 's #6's e-chart and physical chart was from 01/25/13, and reflected one-on-one interaction with sensory stimulation. An interview with the AD on 03/26/15 at 12:17 PM, revealed she had three activity assistants who were each responsible for certain sections of the facility. She stated that they were responsible for completing their activity section of the MDS and care plans. She stated they were responsible for telling how the residents were doing in activities, plus they also put it in their quarterly notes. In those quarterly notes, the AD stated they also discussed preferences, residents' response to activities, and for those that had independence, what they liked to do. The AD provided a blank Admission Assessment form that was to be completed on each resident admitting into the facility. It had 31 detailed questions about their interests. There were no assessments for Resident #5 and #6 available. An interview with Assistant AD VV on 03/26/15 at 12:25 PM, occurred wherein she was asked how she assessed a resident with limited communication like Residents #5 and #6. She replied she adapted to the resident

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F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) because they were not all on the same level. She stated Resident #6 liked to bang one of the drums and enjoyed music. Resident #5 had a recent decline, but prior to that, she was verbal, had friends around the building she spent time with, and played Bingo in the auditorium outside of the secured unit. Interview with Assistant AD UU on 03/26/15 at 1:00 PM, revealed she did assessments when the database told her they were due. She said she put all the notes and assessments in the electronic chart called Point Click Care. Assistants AD UU and VV and the AD were not able to locate any assessment, progress notes, or quarterly updates for Residents #5 and #6 for the past year. Assistant AD UU did not recall if she had completed any for the residents. The facility's Form CMS 672, Resident Census and Conditions of Residents, signed by the DON on 03/22/15, reflected a census of 212 residents. The facility's Room Roster, dated 03/22/15, revealed 23 residents in the secured memory care unit.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (Resident #4 and Resident #21) of thirty residents reviewed for care plans had updated care plans using the results of the assessments to develop and/or revise the resident's comprehensive plan of care. 1) Resident #4 had no updated comprehensive care plan on file since 03/23/14. 2) Resident #21 had no updated comprehensive care plan on file since 02/05/15. This failure affected two (Resident #4 and Resident #21) residents and placed 212 additional residents are risk for not having their needs identified and addressed. Findings included: 1) Resident #4's MDS assessment, dated 02/04/15,reflected the resident was a [AGE] year-old female who had been admitted to the facility on [DATE] and readmitted on [DATE] and 01/22/15 with [DIAGNOSES REDACTED]. The MDS assessment also reflected Resident #4 had unclear speech, rarely she could understand others and rarely staff can understand her, and she had both short-term and long-term memory loss and she was severely cognitively impaired. Resident #4 was totally dependent on two staff for eating, toilet use transfers. She was non-ambulatory. She required extensive assistance of one staff for locomotion around the unit, personal hygiene and bathing. She required dressing with assistance of two staff. She was incontinent of both bowel and bladder. The MDS assessment also reflected Resident #4 received all nutrition from a gastrostomy tube. Review of an MDS assessment (CAA Worksheet), dated 02/04/15, reflected Resident #4's assessment triggered Functional Status, Pain, Nutritional Status, and Medications. Review of Resident #4's clinical record revealed a comprehensive care plan with a initiated date of 03/23/14, a revision date of 03/23/14 and a target date of 05/16/15. The care plan stated Focus: Resident #4 is at risk for an ADL self care performance deficit r/t limited mobility, limited ROM, Alzheimer ' s and Dementia. The goal was to maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the review date. Eating: Resident #4 is able to hold cup, feed self, eat finger foods independently with tray set up. Review of Resident #4's clinical record revealed a comprehensive care plan with a initiated date of 03/23/14, a revision date of 03/23/14 and a target date of 05/16/15. The care plan stated Focus: Resident #4 has the potential for nutritional problem r/t diet restrictions. The goal was to comply with recommended diet daily through review date. Interventions: monitor/document/report to MD PRN, for s/sx of dysphagia: Pocketing, Chocking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, refusing to eat, Appears concerned during meals. Provide, serve diet as ordered. Monitor intake and record q meal. In an interview with the DON on 03/25/15 at 11:51 AM stated I am unsure why the care plans for eating emphasize Resident #4 can hold a cup, feed self, and eat finger foods independently with tray set up. 2) Resident #21's MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male who had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review reflected Resident #21 had clear speech, was understoods/understands, was vision impaired with corrective lenses. Resident #21 required extensive assistance with one person for bed mobility, tranfers, dressing and toilet use while being incontinent with bowel and bladder. Review of an MDS assessment (CAA Worksheet) dated 02/04/15 reflected Resident #21's assessment triggered Cognitive Loss/Dementia, Visual Function, ADL Funtional/Rehabilitation Potential, Falls, Nutritional Status, Pressure Ulcer, [MEDICAL CONDITION] Drug Use, Urinary Incontinence and Indwelling Catheter. Review of Resident #21's clinical record revelaed an admission care plan dated 02/06/15,reflected a focus in the areas of Psychosocial Well-Being, Falls, and Cardiac Difficulty. On 03/26/15 at 10:05 AM, surveyor inquired about Resident #21's care plan and the DON confirmed it had not been updated and stated the Medicare Nurse GGG was responsible for completing the care plan for Resident #21. On 03/27/15 at 11:30 AM, Medicare Nurse GGG stated care plans should be completed 7 days after the completion of the MDS assessment. This staff added she was running behind in computing them. She lastly verified to have now completed Resident #21 comprehensive care plan as of 3/26/15, after the surveyor's inquiry. Review of the Care Plans Policy effective on 10/15/07 stated: PURPOSE: The interdisciplinary team, to coordinate and communicate care approaches and goals for the resident, develops Plans of Care. STANDARD: According to federal regulations, the facility develops a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental/psychosocial needs, that are identified in the comprehensive assessment. The interdisciplinary plan of care committee may consist of. · Nursing personnel having knowledge of the resident · Activities Director · Social Services Director · Dietary Manager · Licensed Therapists · Attending Physician · The resident · Resident's family members, as desired by the resident · Other personnel involved in the resident's care are encouraged to participate The Director of Nursing should oversee the committee and offer assistance in problem solving, as needed. PROCESS: I. Assessment and Plan of Care Process: a. Admission Nutritional Assessment -initiate within 72 hours b. Admission Plan of Care - should be initiated by admitting nurse based on assessment; Dietary Manager should inform the nursing department of any nutritional problems noted in the nutritional assessment, that should be entered on the admission plan of care. c. Resident Assessment Instrument (RAI) - within 14 days of admission; quarterly, annually and with a significant change of condition. d. Comprehensive Plan of Care- within 7 days of Admission RAI; quarterly and with a significant change of condition The facility provided CMS Form 672, which reflected a census of 212.
F 0322 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was fed by a gastrostomy tube received appropriate treatment and services for two (Resident #6 and Resident #4) of three residents reviewed for gastrostomy tubes to prevent aspiration, aspiration pneumonia, dehydration, vomiting, a decreased quality of life and/or possible death. 1) Resident #6's liquid nutritional feedings were being administered by the nursing staff by mouth prior to attempting [DEVICE] feeds and were not being thickened to a nectar thick consistency per doctor orders to prevent silent aspiration. An Immediate Jeopardy (IJ) was identified on 03/24/15. While the IJ was removed on 03/27/15, the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and a scope of pattern, due to the facility still monitoring the effectiveness of the Plan Removal. 2) Resident #4 was disconnected from the feeding pump at times that were not ordered by the physician. This failure could result in potential weight loss. This deficient practice could affect the fifteen residents with gastrostomy tubes and could result in immediate choking and gagging, fluid going into the lung causing aspiration, damage to lungs, pneumonia, repeated episodes of choking and frequent colds, vomiting, a decreased quality of life and death. Findings included: 1) Resident #6's annual MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of [DATE]. [DIAGNOSES REDACTED]. The resident was assessed as severely cognitively impaired for daily decision making. Resident #6 required extensive assistance by one staff for eating, required the use of a feeding tube and a mechanically altered diet. Resident #6's received 51 percent or more of his nutritional via [DEVICE]. A [DEVICE] is a tube inserted through the abdomen into the stomach for the purpose of administering water, liquid nutrition and medications. Resident #6 was initially observed during rounds on 03/22/2015 at 2:17 PM sitting front of the nurses' station. During this observation, the weekend charge nurse, LVN L, described the resident as totally dependent on staff for all ADLs, alert and oriented to person only, incontinent, confused and forgetful, and wearing an abdominal binder because he had pulled out his [DEVICE] within the past week. LVN L

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F 0322 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) said Resident #6 did not speak English and only said a few words. Resident #6's care plan dated 08/21/14 reflected he had the potential for a nutritional problem related to his [DEVICE] diet. The goal was that he would receive pleasure feedings of a pureed diet if he could be fed by staff and would receive bolus feedings ([DEVICE] feedings) five times a day. A Speech Therapy Plan of Care Form with a baseline date of 10/13/14 reflected an evaluation was completed and Resident #6 had severe oropharyngeal dysphagia with mechanical soft food and thin liquids. Oropharyngeal dysphagia occurs when certain conditions weaken throat muscles, making it difficult to move food from the mouth into the throat and esophagus when swallowing is initiated. This could result in a person choking, gagging or coughing when trying to swallow, or have the sensation of food or fluids going down the windpipe (trachea) or up the nose. This may lead to pneumonia (http://www.mayoclinic.org/diseases-conditions/dysphagia/basics/causes/con- 444, 04/09/15). The SLP changed the diet to nectar thick liquids after the evaluation was completed because, The resident ran a runny nose, was coughing, and sneezing during PO intake, decreased oral/pharyngeal function and increased risk for airway obstruction and aspiration. An interview on 03/24/15 at 1:00 PM with the SLP revealed she worked with Resident #6 in the past and he had admitted into the facility with orders for nothing by mouth. She stated she worked very slowly with tactile stimulation on his lips because he was very apprehensive to have anything touch his mouth. She stated after a while, he began to accept lip stimulation, then sugar free flavored sprays, then eventually mechanical soft food with honey thick liquids. The SLP thought Resident #6 admitted with a bolus for feedings and had it the whole time he had been a resident. She stated he went to the hospital recently and his diet was downgraded to pureed pleasure feeds and bolus feedings. The SLP said Resident #6's bolus feeds were to be done via his [DEVICE], not his mouth, because the nutritional supplement was not a thickened liquid. She stated bolus feedings were when the supplement/nutrition was delivered via his [DEVICE]. A Physician order [REDACTED].#6 reflect, May give medications and bolus feedings PO of resident is able to tolerate. A Dysphagia Evaluation dated 10/28/14 reflected the reason for the assessment was because Resident #6 had symptoms of coughing and choking with oral intake, a runny nose and weight loss. The evaluation determined that nectar thick liquids were recommended at that time. The resident was documented at being risk for silent aspiration and the diet order recommendation remained a pureed diet with nectar thick liquids. Silent aspiration is when there is no outward signs of swallowing difficulty; therefore, secretions, food, or liquid enter into the airway, past the vocal folds, and no cough, throat clear or distress occurs (http://www.everythingspeech.com/articles/silent-aspiration, 04/01/15). A Safe Swallow Strategies form for Resident #6 dated 12/02/14 reflected: 1. Current Diet: Pureed/Nectar thick 2. Thicken all liquids to Nectar consistency. Thicken all liquids using thickening powder. All liquids include water, milk, juice, coffee, soda, ice cream, milkshakes, cream soups, clear broths~ anything that can be eaten. 3. Recommend assistance and supervision with feeding. March 2015 Physicians Orders reflected Resident #6 had a diet order for pureed texture, nectar thick consistency, with resident being able to have pleasure feeds with trained staff only. The start date for the order was 09/12/14. The order was for [MEDICATION NAME] 2.0 one can BID and 1 ½ cans BID. The March 2015 Physicians Order did not that any medications or [DEVICE] feedings could be given orally. An interview with LVN N on 03/23/15 at 11:50 AM revealed he fed Resident #6 the nutritional supplement through his mouth rather than through his [DEVICE]. He stated the resident trusted him more now than when he first started working on the unit and that was why he did it. He stated he tried to thicken the nutritional supplement in the past, but the consistency never seemed right and was too thick, so he now administered it at regular consistency. The care plan did not reflect the resident could be fed his nutritional supplement through his mouth if he refused his bolus feeds, nor did the care plan reflect the nutritional supplement had to be thickened to a certain consistency prior to being administered by mouth. An interview with LVN N and SLP occurred on 03/24/15 at 1:15 PM in the dining room. The SLP asked LVN N how he administered Resident #6's bolus feedings. He replied that he always just gave it by mouth, about 2 ½ cups worth. The SLP asked him how he got it to nectar thick consistency and he replied he had tried a few times to add a spoon of thickener but it made it too thick. She said he should have tried a half spoon of thickener instead. He did not reply to her. LVN N stated that the 2:00 PM bolus feeding was given to the resident before lunch around 11:00 AM. When queried why he had given it three hours early, he said when he tried to give the resident his bolus at 2:00 PM in the past, he often would not accept it, so he gave it to him earlier. LVN N stated he also gave Resident #6 his 10:00 AM bolus feeding as well that morning. He revealed the resident was administered approximately five cups of nutritional supplement orally within a one hour time frame. An interview with LVN C on 03/24/15 at 4:05 PM revealed he had been working on the secured unit for three weeks. He stated Resident #6 got his next bolus feeding at 6:00 PM that evening. He stated when he administered the resident's nutritional supplement, the resident would sometimes swat at his head to indicate he did not want the nurse to give him food via his bolus, so he would give it by mouth. LVN C stated he did not thicken the supplement and it was about the consistency of thin milk. An observation on 03/24/15 at 5:12 PM revealed LVN C and MA T in Resident #6's room. LVN C flushed 60 cc of water into his [DEVICE] via a plunger on the syringe. LVN C did not check the [DEVICE] for placement or residuals prior to the water flush. The resident screamed out when the water was plunged into his [DEVICE] and was visibly agitated, grimacing and moving his arms in a defensive position. MA T tried to calm the resident down by talking to him. LVN C poured the [MEDICATION NAME] 2.0 supplement directly into a cup and attempted to pour it twice into the resident's [DEVICE]. When he tried to pour it into the [DEVICE], the resident swiped at his hand and most of the [MEDICATION NAME] spilled on the floor. The LVN stated, See! This is why I have to give it to him by mouth. MA T told LVN C to try and put some music on for Resident #6 to help distract him but the nurse did not put on any music. He got another container of [MEDICATION NAME] 2.0, poured it into a cup, did not thicken it, and tried to give it orally to Resident #6. The resident resisted. LVN C gave the resident the cup of formula but he did not drink it initially. MA T said, Maybe you should just start pouring it into his mouth , LVN C proceeded to administer it orally. Resident #6 attempted to take the cup from LVN C several times. LVN C let the resident take the cup a couple of times and drink from the cup with him standing by watching; sometimes he held the cup with the resident holding it at the same time. The resident had jerky arm movements and his ability to drink from the cup unassisted appeared difficult. LVN C stopped giving [MEDICATION NAME] 2.0 after about a minute passed and measured about 35 cc of [MEDICATION NAME] left in the cup. He said he was throwing it out because the resident drooled and there was too much of the resident's saliva in it. LVN C got another cup and poured the rest of the [MEDICATION NAME] from the original container in it. The resident refused to drink it after a few sips. LVN C said he would try again later. There were 60 cc remaining in the cup. MA T stated the [MEDICATION NAME] 2.0 came in a 250ml container. LVN C was queried during the oral administration of the [MEDICATION NAME] if it was dangerous to give it to the resident. He replied, No. He said he had never seen Resident #6 choke or aspirate before while giving it to him. According to the liquid measurements of [MEDICATION NAME] that remained, Resident #6 was given 155ml of his 250 ml of enteral feeding. An IJ was identified on 03/24/15. On 03/24/15 at 7:40 PM, the Administrator and DON were notified of the IJ and a Plan of Removal was requested at that time. Immediate action taken by the facility after the IJ notification included: - On 3/24/2015, LVN C was removed from the unit and suspended from work at approximately 6:00pm for failure to follow physician orders [REDACTED]. On 3/25/15 at 9:30 AM, LVN C was interviewed regarding occurrences on 3/24/15 and LVN C offered no explanation as to his actions so he was terminated at this time. - - LVN N was in-serviced on insulin administration and suspended on 03/26/15. The DON stated that when interviewed, LVN told them he always thickened the resident's formula when administered orally. - - The resident was assessed on 3/24/2015 by LVN M, for signs and symptoms of aspiration related to receiving thin liquids. No signs/symptoms were noted. (Attachment #3) - On 3/24/2015, the NP was notified regarding the incident. - On 3/25/2015, the resident's responsible party was notified regarding the incident. - On 3/24/2015, the order for administration of [MEDICATION NAME] 2.0 was clarified by Medicare Nurse GGG to show route and thickening consistency of nectar and updated MAR given to 3/24/15 charge nurse on 10-6 shift. - On 3/24/2015, a stat X-ray of the lungs was ordered to rule out aspiration. Results received 3/25/15 and copy of x-ray attached was provided. - On 3/25/2015, a new order was ordered by MD for a Modified [MEDICATION NAME] Swallow Study. MBSS to be completed on 3/26/15. (Attachments #4 and #5) - On 3/25/2015 the resident ' s care plan was reviewed and updated by Medicare Nurse GGG to reflect clarified physician orders. - On 3/25/2015, 33 residents were identified with physician's order [REDACTED]. On 3/25/15 all residents with thickened liquid doctor ' s orders were audited. (Attachment #6) The facility's Plan of Removal, dated 03/25/15, reflected, .The following in-services were provided on March 25, 2015, in-service for all nursing staff (RNs, LVNs, CNAs, and RNAs): 1. Title: Thickening Liquids-Proper nectar consistency, Proper honey consistency, Proper pudding consistency, and Proper stirring instructions 2. Title: Enteral Feeding Administration- Proper formula delivery, Proper use of enteral equipment, Verification of physician order, Proper procedures for enteral tube flushing, Proper syringe administration to end of feeding tube, Gravity method techniques, Never push feeding with plunger or syringe, When to discontinue feedings. 3. Title: Interventions for dealing [MEDICAL CONDITION] (TBI) residents, dementia residents, and difficult or combative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. BUILDING _____ B. WING _____	**03/27/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	**2525 CENTERVILLE RD DALLAS, TX 75228**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0322

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 4)
residents. A post-test will be administered by the (RN, DON) or designee for the above mentioned in-services to ensure competency. Completion Date: All available staff will complete post-test by end of business 3/26/15. The Plan of Removal's systemic change to prevent reoccurrence included, 1) Starting 3/25/2015 and continuing for 90 days, the DON or designee will conduct observation rounds at resident bedside of enteral nutrition administration and review documentation for residents with enteral feedings twice weekly to ensure proper administration of enteral feeding/bolus feeding and that the administration is consistent with physician's orders [REDACTED]. 2) Starting 3/25/2015 and continuing for 90 days, the DON or designee will conduct observation rounds in resident dining areas twice weekly for residents with physician's order [REDACTED]. From 03/24/14-03/27/14, 26 nursing staff members completed in-services and a post-test to ensure competency regarding enteral [DEVICE] feedings. Interviews were conducted with the following: · 6:00 AM- 2:00 PM Staff: LVN V, LVN X, LVN Y, UM F, RN Z, RN BB, LVN H, LVN FF, LVN GG, LVN LL, LVN MM, LVN M · 2:00 PM-10:00 PM: LVN W, LVN CC, LVN DD, LVN EE,
LVN HH, RN NN · 10:00 PM- 6:00 PM: LVN AA, LVN II, LVN JJ, LVN KK, LVN D, LVN NN · PRN and Weekends: LVN J, LVN U An
observation and interview on 03/25/15 at 9:13 AM revealed the SLP was in the dining room stirring thickener into Resident #6 ' s [MEDICATION NAME] 2.0 with LVN N, the DON and the RD present. The SLP said she was making sure it was nectar thick and was thickening it herself. She stood next to LVN N while he orally administered it to the resident. LVN N was asked how Resident #6 ' s medications were administered and he stated via the [DEVICE] if the resident let him, or else he administered them by mouth. He stated the [DEVICE] was small and could take a long time for medications and formula to get down. An observation was made on 03/27/15 of the revised nursing TARs which reflected a place for the nurse to initial when the resident refused his [DEVICE] feedings and indicated if the [MEDICATION NAME] was administered orally and thickened. An interview with the SLP on 03/25/15 at 9:20 AM revealed that a swallow study was in the process of being scheduled and the resident was not at risk for silent aspiration. The SLP said silent aspiration was when a resident drank or ate something, started choking, but was not making any sounds. She said the resident was capable of coughing but did not cough very often. SLP was queried where she got her information that Resident #6 was not at risk of silent aspiration. She replied from his Dysphagia Evaluation swallow study; that he had three of them in the past. SLP was showed the most recent swallow study from October 2014 where it indicated the resident was at risk for silent aspiration. She responded that she did not notice that one and she must have been thinking about one previously from July 2014. An interview with the DON occurred on 03/27/15 at 10:32 AM regarding the Immediate Jeopardy. She stated all the nurses were trained upon hire, received on the floor training and in-services. She stated [DEVICE] and enteral feedings were discussed only upon hire. She said the Staffing Development Nurse did all the initial training. The DON stated the facility did a general competency test and a general orientation with the nurses but did not know if there was a specific question related to enteral [DEVICE] feedings on it. The DON was queried what type of plan was in place to monitor enteral [DEVICE] feedings on the floor prior to the immediate jeopardy. She replied there was no monitoring being done on the floor; no routine checks. She said it was a general competency that nurses should have. The DON did not know if there had been any in-services completed related to enteral [DEVICE] feedings because she had only worked at the facility for two months. When asked how she thought the IJ occurred, she replied it was a breakdown in the thickening of the liquid and the staff were not verifying the doctor orders or the resident ' s diet. The DON did not recall the QA process addressing any areas of concern related to enteral [DEVICE] feedings and diet orders. The IJ was removed on 03/27/15. The ADM and DON were informed of the IJ removal on 03/27/15 at 2:00PM. While the IJ was removed on 03/27/15, the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and a scope of pattern , due to the facility was still monitoring the effectiveness of the Plan Removal. 2)Resident #4's MDS assessment, dated 02/04/15,reflected the resident was a [AGE] year-old female who had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS assessment also reflected Resident #4 had unclear speech, rarely could she understand others and rarely staff can understand her, and she had both short-term and long-term memory loss and she was severely cognitively impaired. Resident #4 was totally dependent on two staff for eating, toilet use transfers. She was non-ambulatory. She required extensive assistance of one staff for locomotion around the unit, personal hygiene and bathing. She required dressing with assistance of two staff. She was incontinent of both bowel and bladder. The MDS assessment also reflected Resident #4 received all nutrition from a gastrostomy tube. Resident #4's current computer-generated Physician order [REDACTED]. X 20 hours=1800cal each shift, and hand written over the computer generated order for [DEVICE] FEEDING DOWN TIME 4 HOURS PER DAY FROM 8AM - 12 noon. Review of
Resident #4's March 2015 MAR indicated [REDACTED]. X 20 hours=1800cal each shift and [DEVICE] FEEDING DOWN TIME 4 HOURS PER
DAY FROM 8AM - 12 noon. Review of Resident #4's revised computer generated Physician order [REDACTED]. X 20 hours=1800cal
each shift, and [DEVICE] FEEDING DOWN TIME 4 HOURS DAILY BETWEEN 1100-1500 (11:00 AM- 3:00 PM). One time a day Order
changed by NP d/t Therapy sessions for resident between this time and resident being a diabetic to prevent [DIAGNOSES REDACTED]. Review of Resident #4's revised March 2015 MAR indicated [REDACTED]. X 20 hours=1800cal each shift and [DEVICE]
FEEDING DOWN TIME 4 HOURS PER DAY FROM 1100-1500 (11:00 AM- 3:00 PM). At 3:26 PM on 03/23/15, Resident #4 was observed in
the lobby not connected to feeding pump. Observation of the [MEDICATION NAME] 1.5 bag revealed 500 mL remaining inside the bag. The bag was hung on 03/23/15 at 0045 AM. At 9:30 AM on 03/24/15 Resident #4 was observed in bed asleep with pump off. The [MEDICATION NAME] 1.5 cal was hung at 430 AM on 03/24/15 with ~800 ml. At 12:00 PM Resident #4 was observed disconnected from her pump and was sitting in the hallway awaiting therapy. At 1:43 PM Resident #4 was not in her room and her pump was off with ~800 ml remaining from the 9:30 observation. At 1:53 PM on 03/24/15 Resident #4 was observed getting off the elevator with Therapist Tech XX. Interview with Therapist Tech XX stated I usually get (Resident #4) after my lunch around 12:30 PM daily for therapy. At 3:54 PM on 03/24/15 Resident #4 was observed sitting in the lobby without her pump. Observation of her pump in her room revealed the [MEDICATION NAME] bag was hung at 0430 AM on 03/24/15 with ~800 ml remaining. The same amount from the observation at 9:30 AM on 03/24/15. In an interview with CNA YY on 03/24/15 at 4:15 PM stated I get her at 2 PM and therapy is just getting through with Resident #4. I was told by therapy not to put (Resident #4) in bed until her therapy session is done with. In an interview with OT K on 03/24/15 at 5:11 PM stated I get Resident #4 for therapy after lunch at 12:30PM. In an interview with the DON on 03/25/15 at 9:20 AM stated I don't know how long therapy has been coming late to get Resident #4 for therapy but currently therapy will get Resident #4 on her downtime. In an interview with the DON on 03/25/15 at 11:51 AM stated I was unaware of the hand written down time on the MAR. The MAR indicated [REDACTED]. In an interview with the Administrator on 03/25/15 at 11:51 AM stated It is not acceptable for a staff member to change the times of downtime on the MAR indicated [REDACTED] An observation on 03/25/15 at 12:28 PM revealed Resident #4 in bed with pump infusing at 60 ml/hr. There was 28ml fed and ~800 ml remaining. The [MEDICATION NAME]
was hung at 5:30 AM on 03/25/15. In an interview with the RD/LD on 03/25/15 at 4:05 PM stated I was not aware of the resident not on the pump during up time. No one informed me. Review of the Progress Note dated 01/28/15 at 18:04 noted Type: Nursing Note Text: Received call from the Dietician. noted [MEDICATION NAME] 1.5 60 ml q hr. x 20 hrs downtime at 8am to 12noon, H20 45cc q hrs. X 20hrs. flush 30cc before and after med administrations. POA was notified. Author: LVN W At the times mentioned below were evidence from the progress notes that Resident #4 was not recieving scheduled feedings on the up time as prescribed by the Physician. Review of Progress Note dated 02/05/15 at 14:17 (2:17 PM) noted: Resident #4 sitting up at the nurses lobby at this time just back from therapy. Author: LVN BBB Review of Progress Note dated 02/11/15 at 14:37 (2:37 PM) noted Resident at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 02/12/15 at 13:25 (1:25 PM) noted Resident at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 02/13/15 at 14:25 (2:25 PM) noted Resident#4 just back from therapy sessions. Author: LVN BBB Review of Progress Note dated 02/16/15 at 13:57 (1:57 PM) noted Resident #4 at therapy sessions at this time Author: LVN BBB Review of Progress Note dated 02/17/15 at 13:31 (1:31 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 02/24/15 at 14:02 (2:02 PM) noted Resident #4 left for therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/02/15 at 13:38 (1:38 PM)noted Resident #4 left for therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/03/15 at 13:40 (1:40 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/09/15 at 14:05 (2:05 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/10/15 at 13:51 (1:51 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/12/15 at 13:19 (1:19 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/16/15 at 12:45PM noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/17/15 at 14:13 (2:13 PM)noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/18/15 at 14:03 (2:03 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/19/15 at 14:07 (2:07 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/23/15 at 13:40 (1:40 PM) noted Resident #4 at therapy sessions at this

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	675081	A. BUILDING _____ B. WING _____	03/27/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0322 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) time. Author: LVN BBB Review of Progress Note dated 03/24/15 at 13:44 (1:44 PM) noted Resident #4 at therapy sessions at this time. Author: LVN BBB Review of Progress Note dated 03/24/15 at 13:54 (1:54 PM) noted Resident #4 back from therapy sessions at this time. Author: LVN BBB The CMS form 672, Resident Census and Conditions of Residents, signed by the DON on 03/22/15, reflected 15 residents with [DEVICE]s and per the interview with the DON, there were four residents including Resident #6 who LVN C and LVN N were responsible for administering medications via their [DEVICE]s.
F 0332 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure the medication error rate was less than 5 percent. Thirty opportunities were observed with a total of three errors, resulting in a ten percent error rate for four residents (Resident #5, #27 and #31). A total of nine residents were observed during the medication pass on 03/23/15 and 03/24/15. 1) LVN C administered the long acting insulin, [MEDICATION NAME] to cover Resident #5's elevated blood glucose instead of the short acting insulin [MEDICATION NAME] as ordered by the physician. An IJ was identified on 03/24/15. The Administrator and DON were notified on 03/24/15 at 7:48 p.m. of the IJ and a Plan of Removal was requested at that time. 2) Licensed Vocational Nurse (LVN) A failed to administer insulin to Resident #27 before lunch according to physician's orders [REDACTED]. 3) Medication Aide (MA) B failed to administer [MEDICATION NAME] before meals according to manufactures specifications. These failures created the potential for residents to have severe [DIAGNOSES REDACTED] (low blood glucose), [MEDICAL CONDITION] (high blood glucose) and experience diabetic complications including coma, kidney failure and death. These failures could affect the 23 residents MA B was assigned to administer oral medications to, the seven residents with a [DIAGNOSES REDACTED]. Findings included: (1) Review of Resident #5's current Minimum Data Set assessment dated [DATE] revealed the resident was an [AGE] year old female admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #5 was initially observed during rounds on 03/22/15 at 3:53 p.m. with LVN L. The resident was sitting in a Geri-chair in the dayroom. LVN L stated the resident was incontinent of bowel/bladder, cognitively impaired and required total care for all activities of daily living. Unit NCH 2- On 03/24/15 at 4:25 p.m. LVN C was observed to obtain a finger stick blood sample from Resident #5. The resident's blood glucose result was 213 milligrams per deciliter mg/dL. LVN C then administered 4 units of [MEDICATION NAME]subcutaneously into the right side of the resident's abdomen. ([MEDICATION NAME]is long-acting insulin used to treat diabetes.) LVN C was queried if he was going to administer any insulin to cover the resident's elevated blood glucose. LVN C stated Resident #5 was ordered to receive [MEDICATION NAME] (Rapid acting insulin used to treat diabetes) insulin but there was none available for the resident. LVN C stated, She is out. LVN C was queried about the differences between the [MEDICATION NAME]he had administered incorrectly and the [MEDICATION NAME]that was ordered to be administered for the sliding scale blood glucose of 213 mg/dL. The nurse stated [MEDICATION NAME]was long acting insulin and [MEDICATION NAME] was short acting insulin. When queried why he administered the incorrect insulin the nurse stated he wanted to make sure the resident had something to treat her elevated blood glucose. LVN C stated he was aware the [MEDICATION NAME]was long acting and would not be effective in lowering the resident's elevated blood glucose quickly. LVN C further stated the [MEDICATION NAME] was ordered on the previous shift by the previous nurse but had not arrived. When queried if there was any [MEDICATION NAME] available in the facility's emergency medication kit, LVN C stated he did not know. Additionally, LVN C stated the resident had only been out of the insulin for his shift (evening) on 03/24/15. Resident #5's consolidated monthly physician's orders [REDACTED]. The orders reflected the resident was ordered to receive [MEDICATION NAME]according to a sliding scale before meals and at bedtime. The resident should have received 4 units of [MEDICATION NAME]instead of the [MEDICATION NAME]. The orders further reflected 4 units of [MEDICATION NAME]were ordered for a blood glucose level of 201 to 250 mg/dL. Resident #5's glucose result was 213 mg/dL. Additionally, the orders reflected 15 units of [MEDICATION NAME]was ordered to be administered at bedtime (8:00 p.m.) On 03/24/15 at 8:00 p.m. the resident would have received the 15 units of routinely scheduled [MEDICATION NAME] resulting in 19 units of [MEDICATION NAME]being administered when only 15 units were ordered by the physician. On 03/24/15 at 5:10 p.m. Unit Manager F (UM) was informed of the medication error. UM F stated insulin should have been ordered every 28 days regardless if the bottle was empty or not. On 03/24/15 at 5:20 p.m. UM F was observed to phone the pharmacy. UM F stated the pharmacy informed her the last time [MEDICATION NAME]for Resident #5 was delivered to the facility was 01/03/15. During the communication with the pharmacy UM F ordered the [MEDICATION NAME]for Resident #5. An interview with LVN N on 03/25/15 at 12:50 p.m. revealed he was the day shift charge nurse on 03/24/15. LVN N stated he was not aware the [MEDICATION NAME]for Resident #5 was not available. He further stated he only used it a few times, was unable to recall when he had used it last but the last time he used it there was insulin left. Additionally, LVN N stated he did not know what had happened to the [MEDICATION NAME] insulin. According to DiabetesNet.com viewed on 04/13/15, [MEDICATION NAME]starts to work about 20 minutes after taken, with a gradual rise (peak) in action over the next 1.75 to 2.25 hours. Action ends in 4.5 to 6 hours. [MEDICATION NAME]starts to work1 to 3 hours after taken and peaks in 8 to 10 hours. The action ends in 18 to 26 hours. According to the [MEDICATION NAME] package insert and label information viewed on DrugInserts.com on 04/13/15, the dose of [MEDICATION NAME]must be individualized based on clinical response. Blood glucose monitoring is essential in all patients receiving insulin therapy. The dosage of [MEDICATION NAME] is based on a medical conditions and response to treatment. Measure each dose very carefully because even small changes in the amount of insulin may have a large effect on blood sugar levels. [DIAGNOSES REDACTED] is the most common adverse reaction of insulin therapy, including [MEDICATION NAME]. Severe [DIAGNOSES REDACTED] can lead to unconsciousness or convulsions and may result in temporary or permanent impairment of brain function or death. On 03/27/15 at 8:50 a.m. RN MM provided the facility's drug reference book, Nursing2014 Drug Handbook 34th edition and identified it as the facility's current drug reference. According to page 748, [MEDICATION NAME]should be administered 5-10 minutes before a meal. (2) Unit Levy 3- On 03/23/15 at 11:30 a.m. LVN A was observed to obtain a finger stick blood sample from Resident #27. The resident's blood glucose result was 224 milligrams per deciliter (mg/dL). LVN A stated the resident was ordered to receive 25 units of regular insulin routinely before the lunch meal daily. LVN A stated she was holding the insulin because she (the nurse) was concerned Resident #27 would not eat well at lunch. LVN A stated recently she had frequently held the resident's insulin because the resident had not been eating well. According to LVN A there was an order to hold the routine insulin if the resident did not eat well. LVN A was queried about how much of the lunch meal Resident #27 had to eat to be considered well. The nurse stated 50 percent. On 03/23/15 at 12:50 p.m. LVN A was observed to administer 25 units of [MEDICATION NAME] Regular insulin into Resident #27's upper left arm at 12:50 p.m. after the resident had completed the lunch meal. Resident #27's consolidated monthly physician's orders [REDACTED]. There were no parameters related to holding Resident #27's insulin. Review of Resident #27's entire clinical record on 03/23/15 revealed there were no orders related to holding the resident's insulin or any documentation the physician had been involved in the decision to hold the insulin. On 03/25/15 the facility's policy/procedures related to sliding scale insulin and blood glucose parameters was requested from the Corporate Nurse. On 03/25/15 at 5:05 p.m. the Corporate Nurse stated there was no specific policy/procedure related to sliding scale insulin administration or blood glucose parameters. She further stated nurses should follow physician's orders [REDACTED]. (3) Unit Levy 2- On 03/24/15 at 9:30 a.m. MA B was observed to prepare and administer medications to Resident #31. Medications included a 20 milligram capsule of [MEDICATION NAME] delayed release (reduces gastric secretions). Resident #31's consolidated monthly physician's orders [REDACTED]. According to the medication administration records the resident was to receive the medication at 7:30 a.m. daily. An interview with MA B on 03/24/15 at 10:00 a.m. revealed she did not administer the medication before the resident's breakfast meal because she had been administering medications downstairs on another floor. MA B stated Resident #31 had completed breakfast. MA B further stated she was responsible for passing oral medications on Unit Levy 1 (rooms 95 to 104) and on Unit Levy 2 (rooms 212 to 223). On 03/24/15 at 10:15 a.m. LVN H provided the facility's drug reference book, Nursing2014 Drug Handbook 34th edition and identified it as the facility's current drug reference. According to page 1026 the medication [MEDICATION NAME] delayed release should have taken one hour before meals. An interview was conducted with the Director of Nurses (DON) on 03/27/15 at 11:23 a.m. The DON was queried about what she expected nursing staff to do if insulin was held. The DON stated she expected nurses to call the physician for instructions. The DON was queried about the facility's policies and procedures related to parameters for holding insulin. The DON stated there were no policies/procedures but she planned to involve the physicians in the development of polices/procedures. When queried if she was aware nurses were indiscriminately holding insulin for Resident #27, the DON replied not until it had been identified by the surveyor. During the interview the DON was queried what training had been provided to nursing staff to ensure they were competent in caring for resident's diagnosed with [REDACTED]. When queried about any specific in-services related to care of residents diagnosed with [REDACTED]. She stated she was unsure of what

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	675081	A. BUILDING _____ B. WING _____	03/27/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING AND REHABILITATION CENTER	2525 CENTERVILLE RD DALLAS, TX 75228

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0332 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) had been provided prior to her employment at the facility. The DON stated she believed LVN N panicked and failed to notify the physician when he realized there was no [MEDICATION NAME]available for Resident #5. According to the American Diabetes Association's web site viewed on 03/31/15 it is important to treat symptoms of high blood sugar right away to help prevent complications. The American Diabetes Association recommends a fasting (before a meal) blood glucose level of 70-130 mg/dL and after meals less than 180 mg/dL. The facility's Plan of Removal was accepted on 03/26/15 and reflected, On 3/24/2015 at roughly 5:30 p.m. the facility determined that there was no [MEDICATION NAME]in the medication cart for (Resident #5)nor was there any [MEDICATION NAME] in the facility's emergency medication kit. The pharmacy was notified of the need to refill the [MEDICATION NAME]and the insulin arrived at the facility on 03/24/15 at 7:45 p.m. All medication carts in the facility were inspected to ensure insulin was present for residents with orders for insulin. LVN C was suspended on 03/24/15. Starting on 3/25/2015, the pharmacy will stock [MEDICATION NAME]in all facility emergency medication kits. In-services were provided to nursing staff as follows: a) Insulin administration, physician orders, validation of physician orders [REDACTED]. b) Proper labeling of insulin bottles, proper amount/dosage, labels matching MAR. c) The six rights of medication administration (the right patient, right medication, right dose, right time, right route and right documentation). d) Verbal orders for drugs and treatments shall be received only by licensed nurses. Verbal orders must be properly recorded immediately. e) Medication refills need to be ordered no less than three (3) days prior to the last dosage being administered. The plan of removal further reflected post-test were being administered to all available nursing staff. Unavailable nursing staff would be tested prior to them working on units. On 3/25/2015 and continuing for the next 90 days, Unit Managers or designees would make bi-weekly audits for insulin availability. On 3/24/2015 and continuing for the next 90 days, the night nurse or designee would verify insulin availability per physician orders [REDACTED]. The orientation of new hires would include training on proper verification of insulin availability per physician orders. Unit Managers or designee will conduct bi-weekly audits of MARS to ensure there have been no incidents of nurses holding scheduled insulin. The orientation of new hires will include training on proper insulin administration and documentation for holding insulin per physician orders. The Administrator/Designee and Director of Nursing/Designee will inspect the results of the bi-weekly audits and the insulin availability verification form during the weekly Standards of Care meeting. Bi-monthly and for the next 90 days the Pharmacy Consultant will observe medication administration to ensure insulin is being properly administered. The Director of Nursing/Designee will meet with Unit Managers and review the results of the bi-weekly audits of MARs during the weekly Standards of Care meeting. Interviews were conducted with nursing staff representing all three shifts, weekends and PRN (as needed) as follows: Interviews were conducted on 03/26/15 between from 10:50 a.m. to 5:20 p.m. with the following nurses, LVN D, H, U, V, W, X, Y, AA, CC, DD, EE, FF, GG, HH, II, JJ, and LL. RN E, RN BB, RN MM and RN Z. On 03/27/15 interviews were conducted with LVN NN and LVN KK at 12:10 a.m. and 1:00 a.m. respectfully. All nurses interviewed stated they had received the above in-service training and post-test. The nurses verbalized they were knew to only administer insulin according to physician orders [REDACTED]. All nurses were aware of the availability and location of insulin in the emergency medication kits. Observation of facility emergency medication kits were conducted on 03/27/15 on the Schepps Unit at 10:00 a.m., the NCH-1 Unit at 10:12 a.m., and the NCH-3 Unit at 10:20 a.m. All three units had specific kits containing various types of insulin for use in case of an emergency. On 03/27/15 the IJ was removed and the Administrato and DON were informed on 03/27/15 at 1:40 p.m. the IJ was removed. While the IJ was removed on 03/27/15, the facility remained out of compliance at scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility was still monitoring the effectiveness of the Plan of Removal. A list provided by the DON on 03/25/15 reflected there were seven residents on Unit L3 and nine residents on Unit N2 with a [DIAGNOSES REDACTED].
F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure two (Resident #5 and #27 were free of any significant medication errors for two of nine observed during the medication pass conducted on 03/23/15 and 03/24/15. 1) LVN C administered the long acting insulin, [MEDICATION NAME] to cover Resident #5's elevated blood glucose instead of the short acting insulin [MEDICATION NAME] as ordered by the physician. An IJ was identified on 03/24/15. The Administrator and DON, were notified on 03/24/15 at 7:48 p.m. of the IJ and a Plan of Removal was requested at that time. 2) Facility nursing staff failed to administer insulin to Resident #27 before meals according to physician's orders [REDACTED]. These failures created the potential for residents to have severe [DIAGNOSES REDACTED] (low blood glucose), [MEDICAL CONDITION] (high blood glucose) and experience diabetic complications including coma, kidney failure and death. These failures could affect the 48 residents identified by the facility who received routine insulin and the 57 residents identified by the facility who received insulin according to a sliding scale (Sliding scale insulin-a set of instructions for administering insulin dosages based on specific blood glucose readings). Findings included: (1) Review of Resident #5's current Minimum Data Set assessment dated [DATE] revealed the resident was an [AGE] year old female admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #5 was initially observed during rounds on 03/22/15 at 3:53 p.m. with LVN L. The resident was sitting in a Geri-chair in the dayroom. LVN L stated the resident was incontinent of bowel/bladder, cognitively impaired and required total care for all activities of daily living. Unit NCH 2- On 03/24/15 at 4:25 p.m. LVN C was observed to obtain a finger stick blood sample from Resident #5. The resident's blood glucose result was 213 milligrams per deciliter mg/dL. LVN C then administered 4 units of [MEDICATION NAME]subcutaneously into the right side of the resident's abdomen. ([MEDICATION NAME]is long-acting insulin used to treat diabetes). LVN C was queried if he was going to administer any insulin to cover the resident's elevated blood glucose. LVN C stated Resident #5 was ordered to receive [MEDICATION NAME] (Rapid acting insulin used to treat diabetes) insulin but there was none available for the resident. LVN C stated, She is out. LVN C was queried about the differences between the [MEDICATION NAME]he had administered incorrectly and the [MEDICATION NAME]that was ordered to be administered for the sliding scale blood glucose of 213 mg/dL. The nurse stated [MEDICATION NAME]was long acting insulin and [MEDICATION NAME] was short acting insulin. When queried why he administered the incorrect insulin the nurse stated he wanted to make sure the resident had something to treat her elevated blood glucose. LVN C stated he was aware the [MEDICATION NAME]was long acting and would not be effective in lowering the resident's elevated blood glucose quickly. LVN C further stated the [MEDICATION NAME] was ordered on the previous shift by the previous nurse but had not arrived. When queried if there was any [MEDICATION NAME] available in the facility's emergency medication kit, LVN C stated he did not know. Additionally, LVN C stated the resident had only been out of the insulin for his shift (evening) on 03/24/15. Resident #5's consolidated monthly physician's orders [REDACTED]. The orders reflected the resident was ordered to receive [MEDICATION NAME]according to a sliding scale before meals and at bedtime. The resident should have received 4 units of [MEDICATION NAME]instead of the [MEDICATION NAME]. The orders further reflected 4 units of [MEDICATION NAME]were ordered for a blood glucose level of 201 to 250 mg/dL. Resident #5's glucose result was 213 mg/dL. Additionally, the orders reflected 15 units of [MEDICATION NAME]was ordered to be administered at bedtime (8:00 p.m.) On 03/24/15 at 8:00 p.m. the resident would have received the 15 units of routinely scheduled [MEDICATION NAME] resulting in 19 units of [MEDICATION NAME]being administered when only 15 units were ordered by the physician. On 03/24/15 at 5:10 p.m. Unit Manager F (UM) was informed of the medication error. UM F stated insulin should have been ordered every 28 days regardless if the bottle was empty or not. On 03/24/15 at 5:20 p.m. UM F was observed to phone the pharmacy. UM F stated the pharmacy informed her the last time [MEDICATION NAME]for Resident #5 was delivered to the facility was 01/03/15. During the communication with the pharmacy UM F ordered the [MEDICATION NAME]for Resident #5. An interview with LVN N on 03/25/15 at 12:50 p.m. revealed he was the day shift charge nurse on 03/24/15. LVN N stated he was not aware the [MEDICATION NAME]for Resident #5 was not available. He further stated he only used it a few times, was unable to recall when he had used it last but the last time he used it there was insulin left. Additionally, LVN N stated he did not know what had happened to the [MEDICATION NAME] insulin. According to DiabetesNet.com viewed on 04/13/15, [MEDICATION NAME]starts to work about 20 minutes after taken, with a gradual rise (peak) in action over the next 1.75 to 2.25 hours. Action ends in 4.5 to 6 hours. [MEDICATION NAME]starts to work1 to 3 hours after taken and peaks in 8 to 10 hours. The action ends in 18 to 26 hours. According to the [MEDICATION NAME] package insert and label information viewed on DrugInserts.com on 04/13/15, the dose of [MEDICATION NAME]must be individualized based on clinical response. Blood glucose monitoring is essential in all patients receiving insulin therapy. The dosage of [MEDICATION NAME] is based on a medical conditions and response to treatment. Measure each dose very carefully because even small changes in the amount of insulin may have a large effect on blood sugar levels. [DIAGNOSES REDACTED] is the most common adverse reaction of insulin therapy, including [MEDICATION NAME]. Severe [DIAGNOSES REDACTED] can lead to unconsciousness or convulsions and

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F 0333

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 7)

may result in temporary or permanent impairment of brain function or death. (2) Review of Resident #27's current Minimum Data Set assessment dated [DATE] revealed the resident was an [AGE] year old female admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #27 was initially observed during rounds on 03/22/15 at 2:30 p.m. with LVN D. The resident was sitting in a reclining chair in her room. The nurse stated the resident was incontinent of bowel/bladder, cognitively impaired and required total care for all activities of daily living. On 03/23/15 at 11:30 a.m. LVN A was observed to obtain a finger stick blood sample from Resident #27. The resident's blood glucose result was 224 milligrams per deciliter (mg/dL). LVN A stated the resident was ordered to receive 25 units of regular insulin routinely before the lunch meal daily. LVN A stated she was holding the insulin because she (the nurse) was concerned Resident #27 would not eat well at lunch. LVN A stated recently she had frequently held the resident's insulin because the resident had not been eating well. According to LVN A there was an order to hold the routine insulin if the resident did not eat well. LVN A was queried about how much of the lunch meal Resident #27 had to eat to be considered well. The nurse stated 50 percent. On 03/23/15 LVN A was observed to administer 25 units of [MEDICATION NAME] Regular insulin into Resident #27's upper left arm at 12:50 p.m. after the resident had completed the lunch meal. Resident #27's consolidated monthly physician's orders [REDACTED]. There were no parameters related to holding Resident #27's insulin. Review of Resident #27's entire clinical record on 03/23/15 revealed there were no orders related to holding the resident's insulin or any documentation the physician had been involved in the decision to hold the insulin. According to the American Diabetes Association's web site viewed on 03/31/15 it is important to treat symptoms of high blood sugar right away to help prevent complications. The American Diabetes Association recommends a fasting (before a meal) blood glucose level of 70-130 mg/dL and after meals less than 180 mg/dL. Review of the resident's medication administration records (MARs) dated March 2015 reflected the [MEDICATION NAME] Regular and the [MEDICATION NAME] had been held (not administered) on the following days: MAR dated March 2015-[MEDICATION NAME]-on
03/03/15 ordered to be administered before dinner. The resident's finger stick blood glucose result was 99 mg/dL. The explanation documented on the back of the MAR indicated [REDACTED]. MAR dated March 2015-[MEDICATION NAME]-on 03/09/15
ordered to be administered before dinner. The resident's finger stick blood glucose result was 72 mg/dL. The explanation documented on the back of the MAR indicated [REDACTED]. An interview with LVN E on 03/26/15 at 10:10 p.m. revealed she was the charge nurse on duty on 03/03/15 and 03/09/15 and had held the insulin for Resident #27. The nurse stated she felt the resident's blood glucose was too low at 99 mg/dL. She further stated a normal blood glucose range was 80 to 120 mg/dL. According to LVN E there was a time in the past when the facility's Nurse Practitioner (NP) told nursing staff to hold Resident #27's insulin when the blood glucose was below 100 mg/dL. The nurse stated the NP provided no specific parameters for holding the insulin other than below 100 mg/dL. According to LVN E she had not observed the resident with any signs/symptoms of [DIAGNOSES REDACTED] (low blood glucose). Additionally, LVN E stated she did not notify the physician, NP
or receive any orders related to holding the resident's insulin. The nurse was unable to recall where the information related to holding the resident's [MEDICATION NAME] had originated. LVN E stated she believed another nurse told her and holding the resident's insulin had been occurring since February 2015. MAR dated March 2015-[MEDICATION NAME] Regular-on 03/10/15 ordered to be administered before lunch. The resident's finger stick blood glucose result was 219 mg/dL. The explanation documented on the back of the MAR indicated [REDACTED]. MAR dated March 2015-[MEDICATION NAME] Regular-on
03/12/15 ordered to be administered before lunch. The resident's finger stick blood glucose result was 170. The explanation documented on the back of the MAR indicated [REDACTED]. MAR dated March 2015-[MEDICATION NAME] Regular-on 03/18/15 ordered
to be administered before lunch. The resident's finger stick blood glucose result was 187. The explanation documented on the back of the MAR indicated [REDACTED]. MAR dated March 2015-[MEDICATION NAME] Regular-on 03/20/15 ordered to be administered before lunch. The resident's finger stick blood glucose result was 174. The explanation documented on the back of the MAR indicated [REDACTED]. Record review of Resident #27's documented meal intake for 03/10/15 reflected there was no documented intake for the entire day. On 03/12/15 the documented meal intake for lunch was 100 percent, on 03/18/15 it was 25 percent and on 03/20/15 it was 100 percent. MAR dated March 2015-[MEDICATION NAME]-on 03/22/15 ordered to be administered before breakfast. The resident's finger stick blood glucose result was 74 mg/dL. The explanation documented on the back of the MAR indicated [REDACTED]. MAR dated March 2015-[MEDICATION NAME]-on 03/23/15 ordered to be administered
before breakfast. The resident's finger stick blood glucose result was 100 mg/dL. The explanation documented on the back of the MAR indicated [REDACTED]. Record review of Resident #27's documented meal intake for 03/23/15 reflected the resident consumed 100 percent of the breakfast meal. An interview with LVN D on 03/26/15 at 5:20 p.m. revealed she was the charge nurse on duty on 03/22/15 and 03/23/15 and had held the insulin for Resident #27. LVN D stated she held the resident's insulin because the resident's blood glucose was below 100 mg/dL. LVN D further stated normal blood glucose ranged from 70 to 100 mg/dL and she had used her nursing judgment to hold the insulin. Additionally, LVN D stated she had informed the NP later in the day of the resident's blood glucose results and of holding the insulin. LVN D further stated she did not recall what the NP said after he was informed but she did not receive any new orders and forgot to document the conversation. Review of nurse's notes for the month of March 2015 revealed there was no documentation the resident's physician had been notified of the nurses holding Resident #27's insulin. On 03/25/15 the facility's policy/procedures related to sliding scale insulin and blood glucose parameters was requested from the Corporate Nurse. On 03/25/15 at 5:05 p.m. the Corporate Nurse stated there was no specific policy/procedure related to sliding scale insulin administration or blood glucose parameters. She further stated nurses should follow physician's orders [REDACTED]. On 03/27/15 at 8:50 a.m. RN MM provided the facility's drug reference book, Nursing2014 Drug Handbook 34th edition and identified it as the facility's current drug reference. According to page 748, [MEDICATION NAME]should be administered 5-10 minutes before a meal. An interview was conducted with the Director of Nurses (DON) on 03/27/15 at 11:23 a.m. The DON was queried about what she expected nursing staff to do if insulin was held. The DON stated she expected nurses to call the physician for instructions. The DON was queried about the facility's policies and procedures related to parameters for holding insulin. The DON stated there were no policies/procedures but she planned to involve the physicians in the development of polices/procedures. When queried if she was aware nurses were indiscriminately holding insulin for Resident #27, the DON replied not until it had been identified by the surveyor. During the interview the DON was queried about what training had been provided to nursing staff to ensure they were competent in caring for resident's diagnosed with [REDACTED]. When queried about any specific in-services related to care of residents diagnosed with [REDACTED]. She further stated she was unsure of what had been provided prior to her employment at the facility. The DON stated she believed LVN N panicked and failed to notify the physician when he realized there was no [MEDICATION NAME]available for Resident #5. The website www.[MEDICATION NAME].com <http://www.[MEDICATION NAME].com> was viewed on 03/31/15 and the section related to warnings and
precautions reflected, Any change of insulin dose should be made cautiously and only under medical supervision. Changing from one insulin product to another or changing the insulin strength may result in the need for a change in dosage. The facility's Plan of Removal, dated 03/25/15, was accepted on 03/26/15 and reflected, On 3/24/2015 at roughly 5:30 p.m. the facility determined that there was no [MEDICATION NAME]in the medication cart for Resident #5 nor was there any [MEDICATION
NAME] in the facility's emergency medication kit. The pharmacy was notified of the need to refill the [MEDICATION NAME]and the insulin arrived at the facility on 03/24/15 at 7:45 p.m. All medication carts in the facility were inspected to ensure insulin was present for residents with orders for insulin. LVN C was suspended on 03/24/15. Starting on 3/25/2015, the pharmacy will stock [MEDICATION NAME]in all facility emergency medication kits. In-services were provided to nursing staff as follows: a) Insulin administration, physician orders, validation of physician orders [REDACTED]. b) Proper labeling of insulin bottles, proper amount/dosage, labels matching MAR. c) The six rights of medication administration (the right patient, right medication, right dose, right time, right route and right documentation). d) Verbal orders for drugs and treatments shall be received only by licensed nurses. Verbal orders must be properly recorded immediately. e) Medication refills need to be ordered no less than three (3) days prior to the last dosage being administered. The plan of removal further reflected post-test were being administered to all available nursing staff. Unavailable nursing staff would be tested prior to them working on units. On 3/25/2015 and continuing for the next 90 days, Unit Managers or designees would make bi-weekly audits for insulin availability. On 3/24/2015 and continuing for the next 90 days, the night nurse or designee would verify insulin availability per physician orders [REDACTED]. The orientation of new hires would include training on proper verification of insulin availability per physician orders. Unit Managers or designee will conduct bi-weekly audits of MARS to ensure there have been no incidents of nurses holding scheduled insulin. The orientation of new hires will include training on proper insulin administration and documentation for holding insulin per physician orders. The Administrator/Designee and Director of Nursing/Designee will inspect the results of the bi-weekly audits and the insulin availability verification form during the weekly Standards of Care meeting. Bi-monthly and for the next 90 days the

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F 0333 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) Pharmacy Consultant will observe medication administration to ensure insulin is being properly administered. The Director of Nursing/Designee will meet with Unit Managers and review the results of the bi-weekly audits of MARs during the weekly Standards of Care meeting. Interviews were conducted with nursing staff representing all three shifts, weekends and PRN (as needed) as follows: Interviews were conducted on 03/26/15 between from 10:50 a.m. to 5:20 p.m. with the following nurses, LVN D, H, U, V, W, X, Y, AA, CC, DD, EE, FF, GG, HH, II, JJ, and LL. RN E, RN BB, RN MM and RN Z. On 03/27/15 interviews were conducted with LVN NN and LVN KK at 12:10 a.m. and 1:00 a.m. respectfully. All nurses interviewed stated they had received the above in-service training and post-test. The nurses were knowledgeable in the different types of insulin and the rate of action different types of insulin. The nurses verbalized they were aware to only administer insulin according to physician orders [REDACTED]. All nurses were aware of the availability and location of insulin in the emergency medication kits. Observation of facility emergency medication kits were conducted on 03/27/15 on the Schepps Unit at 10:00 a.m., the NCH-1 Unit at 10:12 a.m., and the NCH-3 Unit at 10:20 a.m. All three units had specific kits containing various types of insulin for use in case of an emergency. On 03/27/15 the IJ was removed. On 03/27/15 at 1:40 p.m., the Administrator, and DON were informed the IJ was removed. While the IJ was removed, the facility remained out of compliance at scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility was still monitoring the effectiveness of the Plan of Removal. A list provided by the DON on 03/25/15 reflected there were 57 residents in the facility who received insulin according to a sliding scale and 48 residents who received routine insulin.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observation, interview, and record review, it was determined that the facility failed to store, prepare, and serve food under sanitary conditions in one of one kitchen. The DM failed to ensure resident food was stored separately from employee food to prevent cross-contamination. The DM, Dieatary Aide Q and Dietary Aide R failed to perform proper hand hygiene. The DM failed to ensure the dishes were clean and not stacked wet. The DM failed to ensure foods were labeled, dated and stored correctly. The DM failed to ensure thermometers were in all refrigerators and freezers. The DM failed to ensure rotten produce was removed. These failures could affect the 197 residents, who received food from the facility's only kitchen and placed them at risk for food-borne illness, food contamination, and infection. Findings included: An observation on 03/22/15 at 2:33 PM inside the meat kitchen revealed a 2-door refrigerator without a thermometer inside. There were restaurant size containers of mayonnaise, pickles, mustard and etc. Next to the refrigerator was a rack of pots, pans, and skillets. On the rack was five of ten cookie sheets stacked wet. An observation on 03/22/15 at 2:41 PM inside the dairy kitchen revealed a 2-door refrigerator was a package of lunch meat wrapped in saran wrap and some deli style cheese slices wrapped in the same saran wrap next to the meat. The lunch meat and cheese was in the saran wrap together. Interview with Dietary Aide S stated I put it like this but its seperated by plastic dated 03/22/15. There were eight half sandwiches dated 03/22/15 but not labeled. Eight unlabeled cups dated 03/22/15 and Dietary Aide S identified the unlabeled cups as fruit cocktail. An observation on 03/22/15 at 2:47 PM inside the walk-in refrigerator revealed 4 rotten bell peppers inside a produce box with other bell peppers. A tub of unlabeled mixture dated 03/21/15 was on a shelf. Interview with Dietary Aide S identified the unlabeled mixture as tomato soup. An observation on 03/22/15 at 2:52 PM revealed a freezer without a thermometer. On 03/23/15 at 10:28 AM an unlabeled water bottle was found inside a 2-door refrigerator. The DM stated the unidentified water bottle was a staff members ' and threw the bottle in the trash. There were unlabeled white mixture (sour cream) and unlabeled green bean salad. An observation on 03/23/15 at 10:40 AM revealed 10 dirty plates and 5 chipped plates inside the plate warmer. An observation on 03/23/15 at 10:53 AM revealed 18 wet stacked cookie sheets. An observation on 03/23/15 at 11:11 AM revealed the DM, Dietary Aide Q, and Dietary Aide R wash their hands with cold water at a hand wash station. The hot water at this hand wash station did not work only the cold water worked. Interview with the DM, she stated there has been an order put in to get it (sink) fixed. The facility's current policy, Hand-washing Guidelines effective October 15, 2007 reflected, Purpose: To prevent the spread of bacteria that may cause food borne illnesses. Process: II. Hand-washing Procedure: a. Turn on water to a comfortable warm temperature b. Moisten hands with water and apply soap to hands c. Cover hands with soap well beyond the area of contamination d. Wash well under running water for 20-30 seconds e. Pay attention to areas between fingers, around nail beds and under nails f. Rinse hands well under running water; avoid contact with the sink during rinsing. g. Dry hands and turn water off with paper towels touching faucet handles h. Dispose of paper towels in a pedal opening trash can. The facility's current policy, Cleaning of Miscellaneous Equipment and Utensils, effective date October 15, 2007, reflected, Purpose: To prevent the spread of bacteria that may cause food borne illnesses. Process: The Dietary Manager should make cleaning procedures available to staff responsible for cleaning. Basic procedures are as follows: 9. Dishes · Unload soiled food carts by scraping off food from plates and bowls · Soak silverware in presoak solution · Sort and separate glasses and dishes · Stack trays · Rack cups, bowls, and glasses upside down · Place dishes in dish rack ' avoid overloading and nesting · Rinse with dish sink sprayer · Shift rack into dishwasher, lower door, and start machine · Prepare another rack while dishes are washing, continue procedure until all dishes have been washed · Remove first rack to drain board when wash and rinse cycle is complete; allow dishes to air dry. The facility ' s undated policy, Sanitation in Dietary, reflected, Policy: It is the policy of this facility that the food service area shall be maintained in a clean and sanitary manner. Procedures: 3. Plastic ware, china and glassware that cannot be sanitized or are hazardous because of chips, cracks, or loss of glaze shall be discarded. Review of the Resident Census and Conditions of Residents, (CMS Form 672), dated 03/22/15 and signed by the DON revealed a census of 212 residents and there were 15 residents receiving tube feedings. This indicated there were 197 residents, who received their meals from the facility's only kitchen.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the Administrator and DON failed to administer the facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for three (Resident #5, #6 and #27) of 27 residents reviewed for quality of care. 1) The ADM failed to monitor the DON to ensure she carried out her responsibilities to ensure Resident #5's, #6's and #27's needs were met by the nursing staff to include [DEVICE] feeding and insulin administration. Resident #6 ' s liquid nutritional feedings were being administered by the nursing staff by mouth prior to attempting bolus feeds and were not being thickened to a nectar thick consistency per doctor orders to prevent silent aspiration. An Immediate Jeopardy (IJ) was identified on 03/24/15. While the IJ was removed on 03/27/15, the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and a scope of pattern , due to the facility was still monitoring the effectiveness of the Plan Removal. This deficient practice could affect the fifteen residents with gastrostomy tubes and could result in complications relating to aspiration, which could place the residents as risk for damage to their lungs, pneumonia, repeated episodes of choking and frequent colds, vomiting, and a decreased quality of life. These failures could affect the 48 residents identified by the facility who received routine insulin and the 57 residents identified by the facility who received insulin according to a sliding scale (Sliding scale insulin-a set of instructions for administering insulin dosages based on specific blood glucose readings) and created the potential for residents to have severe [MEDICAL CONDITION] (high blood glucose) and to experience diabetic complications including amputations, [MEDICAL CONDITIONS] and kidney disease and death. Findings included: 1) Resident #6 ' s annual MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of [DATE]. [DIAGNOSES REDACTED]. The resident was assessed as severely cognitively impaired for daily decision making. Resident #6 required extensive assistance by one staff for eating, required the use of a feeding tube and a mechanically altered diet. Resident #6's received 51 percent or more of his nutritional via [DEVICE]. A [DEVICE] is a tube inserted through the abdomen into the stomach for the purpose of administering water, liquid nutrition and medications. Resident #6 was initially observed during rounds on 03/22/2015 at 2:17 PM sitting front of the nurses' station. During this observation, the weekend charge nurse, LVN L, described the resident as totally dependent on staff for all ADLs, alert and oriented to person only, incontinent, confused and forgetful, and wearing an abdominal binder because he had pulled out his [DEVICE] within the past week. LVN L said Resident #6 did not speak English and only said a few words. Resident #6's care plan dated 08/21/14 reflected he had the potential for a nutritional problem related to his [DEVICE] diet restriction. The goal was he would receive pleasure feedings of a pureed diet if he could be fed by staff and would receive bolus feedings five times a day. Speech Therapy Plan of Care Form with a baseline date of 10/13/14 reflected an evaluation was completed and Resident #6 had

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) severe oropharyngeal dysphagia with mechanical soft food and thin liquids. Oropharyngeal dysphagia occurs when certain conditions weaken throat muscles, making it difficult to move food from the mouth into the throat and esophagus when swallowing is initiated. This could result in a person choking, gagging or coughing when trying to swallow, or have the sensation of food or fluids going down the windpipe (trachea) or up the nose. This may lead to pneumonia (http://www.mayoclinic.org/diseases-conditions/dysphagia/basics/causes/con- 444, 04/09/15). The SLP changed the diet to pureed food, nectar thick liquids after the evaluation was completed because, The resident ran a runny nose, was coughing, and sneezing during PO intake, decreased oral/pharyngeal function and increased risk for airway obstruction and aspiration. An interview on 03/24/15 at 1:00 PM with the SLP revealed she worked with Resident #6 in the past and he had admitted into the facility with orders for nothing by mouth. She stated she worked very slowly with tactile stimulation on his lips because he was very apprehensive to have anything touch his mouth. She stated after a while, he began to accept lip stimulation, then sugar free flavored sprays, then eventually mechanical soft food with honey thick liquids. The SLP thought Resident #6 admitted with a bolus for feedings and had it the whole time he had been a resident. She stated he went to the hospital recently and his diet was downgraded to pureed pleasure feeds and bolus feedings. The SLP said Resident #6's bolus feeds were to be done via his [DEVICE], not his mouth, because the nutritional supplement was not a thickened liquid. She stated bolus feedings were when the supplement/nutrition was delivered via his [DEVICE]. March 2015 Physicians Orders reflected Resident #6 had a diet order for pureed texture, nectar thick consistency, with resident being able to have pleasure feeds with trained staff only. The order was for [MEDICATION NAME] 2.0 one can two times a day for enteral feed and 1 ½ can of [MEDICATION NAME] two times a day. The Physicians Order did not reflect what to do if the resident refused his [DEVICE] feedings. A Dysphagia Evaluation dated 10/28/14 reflected the reason for the assessment was because Resident #6 had symptoms of coughing and choking with oral intake, a runny nose and weight loss. The evaluation determined that nectar thick liquids were recommended at that time. The resident was documented at being risk for silent aspiration and the diet order recommendation remained a pureed diet with nectar thick liquids. Silent aspiration is when there is no outward signs of swallowing difficulty; therefore, secretions, food, or liquid enter into the airway, past the vocal folds, and no cough, throat clear or distress occurs (http://www.everythingspeech.com/articles/silent-aspiration, 04/01/15). A Safe Swallow Strategies form dated 12/02/14 reflected: 1. Current Diet: Pureed/Nectar thick 2. Thicken all liquids to Nectar consistency. Thicken all liquids using thickening powder. All liquids include water, milk, juice, coffee, soda, ice cream, milkshakes, cream soups, clear broths~ anything that can be eaten. 3. Recommend assistance and supervision with feeding. A physician ' s progress note dated 01/14/15 reflected Resident #6 was seen at the request of staff due to a fever and a cough. Staff reported multiple residents on the secured unit were having upper respiratory symptoms. Resident was on [MEDICATION NAME] due to symptoms of the flu and was started on a Z-Pak (antibiotic) due to an increased risk of secondary bacterial infection. An interview with LVN N on 03/23/15 at 11:50 AM revealed he fed Resident #6 the nutritional supplement through his mouth rather than through his [DEVICE]. He stated the resident trusted him more now than when he first started working on the unit and that was why he did it. He stated he tried to thicken the nutritional supplement in the past, but the consistency never seemed right and was too thick, so he now administered it at regular consistency. The care plan did not reflect the resident could be fed his nutritional supplement through his mouth if he refused his bolus feeds, nor did the care plan reflect the nutritional supplement had to be thickened to a certain consistency prior to being administered by mouth. An interview with LVN N on 03/24/15 at 1:15 PM with the SLP revealed when the SLP asked LVN N how he administered Resident #6's bolus feedings. He replied that he always just gave it by mouth, about 2 ½ cups worth. The SLP asked him how he got it to nectar thick consistency and he replied he had tried a few times to add a spoon of thickener but it made it too thick. She said he should have tried a half spoon of thickener instead. He did not reply. LVN N stated that the 2:00 PM bolus feeding was given to the resident before lunch. When queried why he had given it three hours early, he said when he tried to give the resident his bolus at 2:00 PM, he often would not accept it, so he gave it to him earlier. LVN N stated he also gave Resident #6 his 10:00 AM bolus feeding and 11:00 AM bolus feeding. He revealed the resident was administered approximately five cups of nutritional supplement orally within a one hour time frame. An interview with LVN C on 03/24/15 at 4:05 PM revealed he had been working on the secured unit for three weeks. He stated Resident #6 got his next bolus feeding at 6:00 PM that evening. He stated when he administered the resident's nutritional supplement, the resident would sometimes swat at his head to indicate he did not want the nurse to give him food via his bolus, so he would give it by mouth. LVN C stated he did not thicken the supplement and it was about the consistency of thin milk. An observation on 03/24/15 at 5:12 PM revealed LVN C and MA T in Resident #6 ' s room. LVN C flushed 60 cc of water into his [DEVICE] via a plunger on the syringe. LVN C did not check the [DEVICE] for placement or residuals prior to the water flush. The resident screamed out when the water was plunged into his [DEVICE] and was visibly agitated, grimacing and moving his arms in a defensive position. MA T tried to calm the resident down by talking to him. LVN C poured the [MEDICATION NAME] 2.0 supplement directly into a cup and attempted to pour it twice into the resident's [DEVICE]. LVN C did not thicken the [MEDICATION NAME] prior to putting it in his [DEVICE]. When he tried to pour it into the [DEVICE], the resident swiped at his hand and most of the [MEDICATION NAME] spilled on the floor. The LVN stated, See! This is why I have to give it to him by mouth. MA T told LVN C to try and put some music on for Resident #6 to help distract him but the nurse did not put on any music. He got another container of [MEDICATION NAME] 2.0, poured it into a cup, did not thicken it, and tried to give it orally to Resident #6. The resident resisted. LVN C gave the resident the cup of formula but he did not drink it initially. MA T said, Maybe you should just start pouring it into his mouth , LVN C proceeded to administer it orally. Resident #6 attempted to take the cup from LVN C several times. LVN C let the resident take the cup a couple of times and drink from the cup with him standing by watching; sometimes he held the cup with the resident holding it at the same time. The resident had jerky arm movements and his ability to drink from the cup unassisted appeared difficult. LVN C stopped giving [MEDICATION NAME] 2.0 after about a minute passed and measured about 35 cc of [MEDICATION NAME] left it the cup. He said he was throwing it out because the resident drooled and there was too much of the resident's saliva in it. LVN C got another cup and poured the rest of the [MEDICATION NAME] from the original container in it. The resident refused to drink it after a few sips. LVN C said he would try again later. There were 60 cc remaining in the cup. MA T stated the [MEDICATION NAME] 2.0 came in a 250ml container. LVN C was queried during the oral administration of the [MEDICATION NAME] if it was dangerous to give it to the resident. He replied, No. He said he had never seen Resident #6 choke or aspirate before while giving it to him. According to the liquid measurements of [MEDICATION NAME] that remained, Resident #6 was given 155ml of his 250 ml of enteral feeding. An Immediate Jeopardy (IJ) was identified on 03/24/15 at 7:40 PM. On 03/24/15 at 7:40 PM, the Administrator and DON were notified of the IJ and a Plan of Removal was requested at that time.While the IJ was removed on 03/27/15 at 2:00 PM, the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and a scope of pattern, due to the facility was still monitoring the effectiveness of the Plan Removal. Immediate action taken by the facility after the IJ notification included: - On 3/24/2015, LVN C was removed from the unit and suspended from work at approximately 6pm for failure to follow physician orders [REDACTED]. On 3/25/15 at 9:30 AM, LVN C was interviewed regarding occurrences on 3/24/15 and Joseph offered no explanation as to his actions so he was terminated at this time. - LVN N was in-serviced on insulin administration and suspended on 03/26/15. The DON stated that when interviewed, LVN told them he always thickened the resident ' s formula when administered orally. - The resident was assessed on 3/24/2015 by LVN M, for signs and symptoms of aspiration related to receiving thin liquids. No signs/symptoms were noted. (Attachment #3) - On 3/24/2015, the NP was notified regarding the incident. - On 3/25/2015, the resident ' s responsible party was notified regarding the incident. - On 3/24/2015, the order for administration of [MEDICATION NAME] 2.0 was clarified by Medicare Nurse GGG to show route and thickening consistency of nectar and updated MAR given to 3/24/15 charge nurse on 10-6 shift. - On 3/24/2015, a stat X-ray of the lungs was ordered to rule out aspiration. Results received 3/25/15 and copy of x-ray attached was provided. - On 3/25/2015, a new order was ordered by MD for a Modified [MEDICATION NAME] Swallow Study. MBSS to be completed on 3/26/15. (Attachments #4 and #5) - On 3/25/2015 the resident ' s care plan was reviewed and updated by Medicare Nurse GGG to reflect clarified physician orders. - On 3/25/2015, 33 residents were identified with physician's order [REDACTED]. On 3/25/15 all residents with thickened liquid doctor ' s orders were audited. (Attachment #6) The facility's Plan of Removal, dated 03/25/15, reflected, .The following in-services were provided on March 25, 2015, in-service for all nursing staff (RNs, LVNs, CNAs, and RNAs): 1. Title: Thickening Liquids-Proper nectar consistency, Proper honey consistency, Proper pudding consistency, and Proper stirring instructions 2. Title: Enteral Feeding Administration- Proper formula delivery, Proper use of enteral equipment, Verification of physician order, Proper procedures for enteral tube flushing, Proper syringe administration to end of feeding tube, Gravity method techniques, Never push feeding with plunger or syringe, When to discontinue feedings. 3.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) Title: Interventions for dealing [MEDICAL CONDITION] (TBI) residents, dementia residents, and difficult or combative residents. A post-test will be administered by the (RN, DON) or designee for the above mentioned in-services to ensure competency. Completion Date: All available staff will complete post-test by end of business 3/26/15. The Plan of Removal's systemic change to prevent reoccurrence included, 1) Starting 3/25/2015 and continuing for 90 days, the DON or designee will conduct observation rounds at resident bedside of enteral nutrition administration and review documentation for residents with enteral feedings twice weekly to ensure proper administration of enteral feeding/bolus feeding and that the administration is consistent with physician's orders [REDACTED]. 2) Starting 3/25/2015 and continuing for 90 days, the DON or designee will conduct observation rounds in resident dining areas twice weekly for residents with physician's order [REDACTED]. From 03/24/14-03/27/14, 26 nursing staff members completed in-services and a post-test to ensure competency regarding enteral [DEVICE] feedings. Interviews were conducted with the following: · 6:00 AM- 2:00 PM Staff: LVN V, LVN X, LVN Y, UM F, RN Z, RN BB, LVN H, LVN FF, LVN GG, LVN LL, LVN MM, LVN M · 2:00 PM-10:00 PM: LVN W, LVN CC, LVN DD, LVN EE, LVN HH, RN NN · 10:00 PM- 6:00 PM: LVN AA, LVN II, LVN JJ, LVN KK, LVN D, LVN NN · PRN and Weekends: LVN J, LVN U An observation and interview on 03/25/15 at 9:13 AM revealed the SLP was in the dining room stirring thickener into Resident #6 ' s [MEDICATION NAME] 2.0 with LVN N, the DON and the RD present. The SLP said she was making sure it was nectar thick and was thickening it herself. She stood next to LVN N while he orally administered it to the resident. LVN N was asked how Resident #6 ' s medications were administered and he stated via the [DEVICE] if the resident let him, or else he administered them by mouth. He stated the [DEVICE] was small and could take a long time for medications and formula to get down. An interview with the SLP on 03/25/15 at 9:20 AM revealed that a swallow study was in the process of being scheduled and the resident was not at risk for silent aspiration. The SLP said silent aspiration was when a resident drank or ate something, started choking, but was not making any sounds. She said the resident was capable of coughing but did not cough very often. SLP was queried where she got her information that Resident #6 was not at risk of silent aspiration. She replied from his Dysphagia Evaluation swallow study; that he had three of them in the past. SLP was showed the most recent swallow study from October 2014 where it indicated the resident was at risk for silent aspiration. She responded that she did not notice that one and she must have been thinking about one previously from July 2014. An interview with the DON occurred on 03/27/15 at 10:32 AM regarding the Immediate Jeopardy. She stated all the nurses were trained upon hire, received on the floor training and in-services. She stated [DEVICE] and enteral feedings were discussed only upon hire. She said the Staffing Development Nurse did all the initial training. The DON stated the facility did a general competency test and a general orientation with the nurses but did not know if there was a specific question related to enteral [DEVICE] feedings on it. The DON was queried what type of plan was in place to monitor enteral [DEVICE] feedings on the floor prior to the immediate jeopardy. She replied there was no monitoring being done on the floor; no routine checks. She said it was a general competency that nurses should have. The DON did not know if there had been any in-services completed related to enteral [DEVICE] feedings because she had only worked at the facility for two months. When asked how she thought the IJ occurred, she replied it was a breakdown in the thickening of the liquid and the staff were not verifying the doctor orders or the resident ' s diet. The DON did not recall the QA process addressing any areas of concern related to enteral [DEVICE] feedings and diet orders. Immediate action taken by the facility after the IJ notification included: - On 3/24/2015, LVN C was removed from the unit and suspended from work at approximately 6pm for failure to follow physician orders [REDACTED]. On 3/25/15 at 9:30 AM, LVN C was interviewed regarding occurrences on 3/24/15 and Joseph offered no explanation as to his actions so he was terminated at this time. - - LVN N was in-serviced on insulin administration and suspended on 03/26/15. The DON stated that when interviewed, LVN told them he always thickened the resident ' s formula when administered orally. - - The resident was assessed on 3/24/2015 by LVN M, for signs and symptoms of aspiration related to receiving thin liquids. No signs/symptoms were noted. (Attachment #3) - On 3/24/2015, the NP was notified regarding the incident. - On 3/25/2015, the resident ' s responsible party was notified regarding the incident. - On 3/24/2015, the order for administration of [MEDICATION NAME] 2.0 was clarified by Medicare Nurse GGG to show route and thickening consistency of nectar and updated MAR given to 3/24/15 charge nurse on 10-6 shift. - On 3/24/2015, a stat X-ray of the lungs was ordered to rule out aspiration. Results received 3/25/15 and copy of x-ray attached was provided. - On 3/25/2015, a new order was ordered by MD for a Modified [MEDICATION NAME] Swallow Study. MBSS to be completed on 3/26/15. (Attachments #4 and #5) - On 3/25/2015 the resident ' s care plan was reviewed and updated by Medicare Nurse GGG to reflect clarified physician orders. - On 3/25/2015, 33 residents were identified with physician's order [REDACTED]. On 3/25/15 all residents with thickened liquid doctor ' s orders were audited. (Attachment #6) The facility's Plan of Removal, dated 03/25/15, reflected, .The following in-services were provided on March 25, 2015, in-service for all nursing staff (RNs, LVNs, CNAs, and RNAs): 1. Title: Thickening Liquids-Proper nectar consistency, Proper honey consistency, Proper pudding consistency, and Proper stirring instructions 2. Title: Enteral Feeding Administration- Proper formula delivery, Proper use of enteral equipment, Verification of physician order, Proper procedures for enteral tube flushing, Proper syringe administration to end of feeding tube, Gravity method techniques, Never push feeding with plunger or syringe, When to discontinue feedings. 3. Title: Interventions for dealing [MEDICAL CONDITION] (TBI) residents, dementia residents, and difficult or combative residents. The Plan of Removal's systemic change to prevent reoccurrence included, 1) Starting 3/25/2015 and continuing for 90 days, the DON or designee will conduct observation rounds at resident bedside of enteral nutrition administration and review documentation for residents with enteral feedings twice weekly to ensure proper administration of enteral feeding/bolus feeding and that the administration is consistent with physician's orders [REDACTED]. 2) Starting 3/25/2015 and continuing for 90 days, the DON or designee will conduct observation rounds in resident dining areas twice weekly for residents with physician's order [REDACTED]. After the Plan of Removal was accepted, and an interview with the ADM on 03/27/15 at 10:59 AM revealed he had daily stand-up meetings with all disciplines. During those meetings, staff brought up concerns and the 24-hour report was covered. The ADM stated he had standard of care meetings weekly where topics such as weights and psychoactive medication were discussed. He also stated there was a daily meeting regarding any falls that had occurred. The ADM stated all the areas of concern are brought to the monthly Quality Assurance meetings, tracked and trended. The ADM stated when there were certain concerns, the facility would complete an audit and tracking depended on the area of concern by the ADM, DON and Unit Managers and brought back to the Quality Assurance Meetings. If an area of concern did not improve, the ADM stated he would discuss it as a team and change it, and try to find the root cause of the problem. After a concern was identified, the ADM would address it by completing a plan of action, assigning someone to track and trend it. Regarding bolus feedings, the ADM stated there needed to be continual training to the staff members specific to those things, chart audits related to physician orders [REDACTED]. He stated that maybe the sample size audited needed to be increased. The ADM stated the QA process had not identified any enteral feeding issues since he had been working at the facility, which was two months. A list of personnel provided by the HR director on 03/23/15 reflected the Administrator was hired on 08/08/14 and the DON was hired on 01/01/15. The ADM ' s job description, reflected, PURPOSE of YOUR JOB POSITION: The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality of care can be provided to our residents at all times, ., DUTIES and RESPONSIBILITIES: · Plan, organize, implement, evaluate and direct the facility ' s programs and activities. · Develop and maintain written policies and procedures that govern the operation of the facility. · Make routine inspections of the facility to make assure the established policies and procedures are being met and followed. · Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services. · Review and check competence of work force and make necessary adjustments/corrections as required. 2) On 3/24/2015 at roughly 5:30 p.m. the facility determined that there was no [MEDICATION NAME]in the medication cart for Resident #5 nor was there any [MEDICATION NAME] in the facility's emergency medication kit. The pharmacy was notified of the need to refill the [MEDICATION NAME]and the insulin arrived at the facility on 03/24/15 at 7:45 p.m. All medication carts in the facility were inspected to ensure insulin was present for residents with orders for insulin. LVN C was suspended on 03/24/15. Starting on 3/25/15, the pharmacy will stock [MEDICATION NAME]in all facility emergency medication kits. In-services were provided to nursing staff as follows: a) Insulin administration, physician orders, validation of physician orders [REDACTED]. b) Proper labeling of insulin bottles, proper amount/dosage, labels matching MAR. c) The six rights of medication administration (the right patient, right medication, right dose, right time, right route and right documentation). d) Verbal orders for drugs and treatments shall be received only by licensed nurses. Verbal orders must be properly recorded immediately. e) Medication refills need to be ordered no less than three (3) days prior to the last dosage being administered. The plan of removal further reflected post test were being administered to all available nursing staff. Unavailable nursing staff would

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 11) be tested prior to them working on units. On 3/25/2015 and continuing for the next 90 days, Unit Managers or designees would make bi-weekly audits for insulin availability. On 3/24/2015 and continuing for the next 90 days, the night nurse or designee would verify insulin availability per physician orders [REDACTED]. The orientation of new hires would include training on proper verification of insulin availability per physician orders. Unit Managers or designee will conduct bi-weekly audits of MARS to ensure there have been no incidents of nurses holding scheduled insulin. The orientation of new hires will include training on proper insulin administration and documentation for holding insulin per physician orders. The Administrator/Designee and Director of Nursing/Designee will inspect the results of the bi-weekly audits and the insulin availability verification form during the weekly Standards of Care meeting. Bi-monthly and for the next 90 days the Pharmacy Consultant will observe medication administration to ensure insulin is being properly administered. The Director of Nursing/Designee will meet with Unit Managers and review the results of the bi-weekly audits of MARs during the weekly Standards of Care meeting. Interviews were conducted with nursing staff representing all three shifts, weekends and PRN (as needed) as follows: Interviews were conducted on 03/26/15 between from 10:50 a.m. to 5:20 p.m. with the following nurses, LVN D, H, U, V, W, X, Y, AA, CC, DD, EE, FF, GG, HH, II, JJ, and LL. RN E, RN BB, RN MM and RN Z. On 03/27/15 interviews were conducted with LVN NN and LVN KK at 12:10 a.m. and 1:00 a.m. respectfully. All nurses interviewed stated they had received the above in-service training and post-test. The nurses were knowledgeable in the different types of insulin and the rate of action different types of insulin. The nurses verbalized they were aware to only administer insulin according to physician orders [REDACTED]. All nurses were aware of the availability and location of insulin in the emergency medication kits. Observation of facility emergency medication kits were conducted on 03/27/15 on the Schepps Unit at 10:00 a.m., the NCH-1 Unit at 10:12 a.m., and the NCH-3 Unit at 10:20 a.m. All three units had specific kits containing various types of insulin for use in case of an emergency. An interview was conducted with the Director of Nurses (DON) on 03/27/15 at 11:23 a.m. The DON was queried about what she expected nursing staff to do if insulin was held. The DON stated she expected nurses to call the physician for instructions. The DON was queried about the facility's policies and procedures related to parameters for holding insulin. The DON stated there were no policies/procedures but she planned to involve the physicians in the development of polices/procedures. When queried if she was aware nurses were indiscriminately holding insulin for Resident #27, the DON replied not until it had been identified by the surveyor. During the interview the DON was queried what training had been provided to nursing staff to ensure they were competent in caring for resident's diagnosed with [REDACTED]. MORE THAN LVN A WHAT? When queried about any specific in-services related to care of residents diagnosed with [REDACTED]. She stated she was unsure of what had been provided prior to her employment at the facility. The DON stated she believed LVN N panicked and failed to notify the physician when he realized there was no [MEDICATION NAME]available for Resident #5. CMS form 672, Resident Census and Conditions of Residents, signed by the DON on 03/22/15, reflected 15 residents with [DEVICE]s and per the interview with the DON, there were four residents including Resident #6 who LVN C and LVN N were responsible for administering medications via their [DEVICE]s. A list provided by the DON on 03/25/15 reflected there were 57 residents in the facility who received insulin according to a sliding scale and 48 residents who received routine insulin.
F 0518 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Train all employees on what to do in an emergency, and carry out announced staff drills.** Based on interview and record review, it was determined the facility failed to ensure two (CNA G and CNA OO) of three staff interviewed had been effectively trained in all aspects of the facility's emergency and disaster preparedness plan, including evacuation order, how to operate a fire extinguisher, and power outage procedures. The facility must train all employees in emergency procedures when they begin to work the facility: periodically review the procedures with existing staff: and carry out unannounced staff drills using those procedures.(CNA G and CNAOO worked the day and evening shift respectively.) 1. CNA G did not know how to operate a fire extinguisher correctly. 2. CNA OO did not know the correct order of evacuation during a fire. 3. CNA OO did not know the purpose of the generator power-supplied duplex receptacles (red outlets). These failures could affect all 212 residents by placing them at risk for harm in the event of an emergency or disaster at the facility. Findings included: 1) CNA G was interviewed regarding the facility's emergency preparedness procedures on 03/26/15 at 1:05 PM. When asked how to operate the fire extinguisher in the event of a fire, CNA G responded she would press on the top of the handle and aim at the fire. On 3/27/15 at 10:35 AM, the Maintenance Supervisor was interviewed and stated all staff were trained in orientation using the PASS (Pull, Aim, Squeeze, Sweep) method. He further stated every fire drill we ask the nursing staff how they use the fire extinguisher, and that occurred one time a month on each shift. 2) CNA OO was interviewed regarding the facility's emergency preparedness procedures on 03/24/15 at 12:11 PM. When asked for the order of resident evacuation, CNA OO responded he would move the bedfast residents first because they need some assistance, followed by the chair-bound residents, and then the ambulatory residents. 3) CNA OO was interviewed regarding the facility's emergency preparedness procedures on 03/24/25 at 12:11 PM. When asked the purpose of the generator power-supplied duplex receptacles (red outlets), CNA OO replied, the outlets were the special outlets with trip overload protection (ground fault circuit interrupter). CNA OO was then taken to one of the duplex receptacles with a red face plate and asked again, what the outlet was for. At that point, CNA OO stated it was not an outlet with a trip overload protector and that he did not know what it was used for. 4) Review of the facility's fire evacuation Plan for emergency preparedness policies, dated as implemented on 07/97, and provided by the facility as the current policy, revealed the following instructions for operation of the fire extinguisher: How to work Most Extinguishers Using PASS Method 1. Pull pull the pin. 2. Aim Aim the extinguisher nozzle (horn or hose) at the base of the fire. 3. Squeeze Squeeze or press the handle. 4. Sweep Sweep from side to side at the base of the fire. Watch for reflash. Move in close; pull apart the burned area to get at hot spots, if possible. discharge the contents of the extinguishers. 5) Review of the facility's disaster manual revealed a policy regarding the evacuation order in the event of a fire, revised in 2009 revealed: Evacuation Order: 1. Ambulatory residents are to be evacuated first. The residents should be assembled, instructed to form a chain by holding hands and then moved as a group. 2. Wheelchair residents are to be evacuated second. 3. Bedfast residents are to be evacuated last. 6) Review of the facility's disaster manual revealed a policy regarding Fire Disaster and Life Safety Preventative Maintenance. This policy was dated 01/25/10: PURPOSE: To ensure power to needed rooms during power failure (i.e. O2, IV's Air Mattress, etc.) STANDARD: As part of disaster planning, the facility should prepare a contingency plan, in the event of loss of normal power. PROCESS: During power outage, plug the extension cord into the red outlet in the hall. Connect a surge protector Multi Outlet into the end of the extension cord. Connect the extension cord to the room in need of emergency power. Keep extension cord safely ran down the sides of the halls. Connect extension cord to IV, O2, Air Mattress, etc. 7) Form CMS-672, Resident Census and Conditions of Residents, signed and dated by the DON on 03/22/15 reflected there were 212 residents in the facility.